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A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

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N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Basic Treatment Method

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

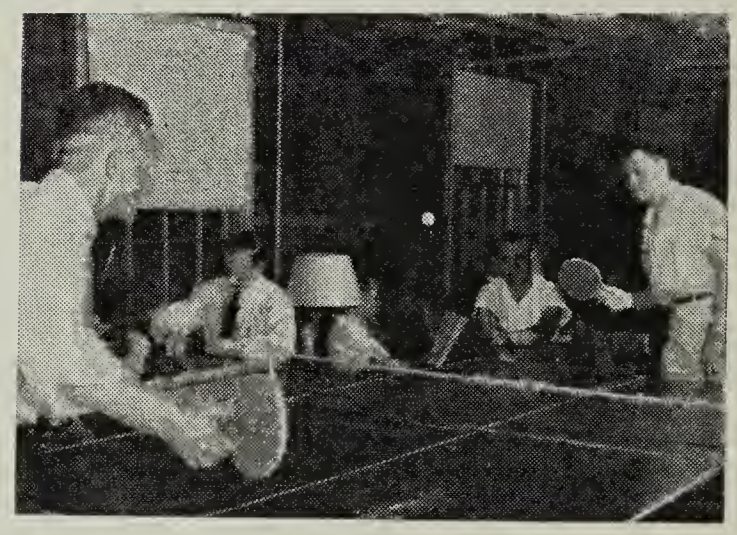
The Basic Patient

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

VOLUME VI NUMBER 1

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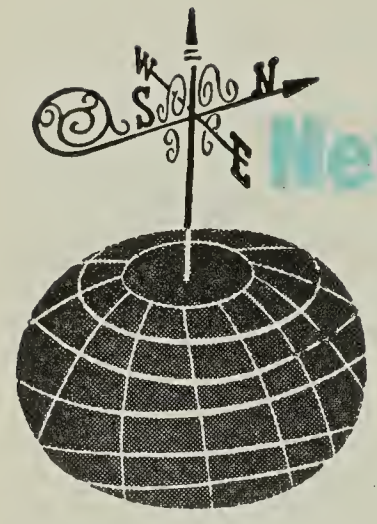
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News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

SUMMER SCHOOLS FOR TEACHERS

NORTH CAROLINA. In recognition of the great need for objective teaching about alcohol and alcoholism in our public school system, the NCARP in cooperation with several colleges will again this summer present several ten-day study courses for teachers on Facts About Alcohol. Offering three-quarter hours college credit, the courses will be given at the following colleges at the times indicated: East Carolina College, Greenville, June 5-15; North Carolina College, Durham, June 12-22; Fayetteville State Teachers College, Fayetteville, June 25-July 6; A.&T. College, Greensboro, June 18-29; and Appalachian State Teachers College, Boone, July 9-20. Applications for admission and other correspondence should be addressed to The Director of Summer Session at the appropriate college.

ALCOHOLISM INSTITUTE FOR CLERGYMEN

NEW HAMPSHIRE. The second annual North Conway Institute on Alcoholism (for clergymen) will be held at North Conway June 18-22 under the direction of Rev. David A. Works. Among the lecturers will be: Rev. John C. Ford and other church leaders, Harold Demone of the N. H. Alcoholic Rehabilitation Program, Dr. Robert Straus, co-author of "Drinking In College," Dr. Ebbe C. Hoff of the Medical College of Virginia, and Army and Navy personnel. Address correspondence to Rev. Works, Rector of Christ Church, North Conway.

FEMALE ALCOHOLISM RATE SAID INCREASING

SWITZERLAND. According to Dr. E. M. Jellinek, consultant to the United Nations World Health Organization, alcoholism is increasing among American women at a more rapid rate than among men. He attributes the change partly to the growing earning power of American women. "When women compete in the professional field with men," Jellinek said, "they tend to adopt some of the outward signs of the male culture."

BIG BUDGET FOR ALCOHOLIC REHABILITATION

CALIFORNIA. The Governor and the Legislature have approved a whopping $704,798 fiscal year budget for the State Alcoholic Rehabilitation Commission. This will be allocated as follows for the 1956-57 year: Treatment, $423,200; Research, $190,000; Information, $22,407; Administration, $69,191.

CONSOLIDATED EDISON PROGRAM PAYS OFF

NEW YORK. An evaluation of its alcoholic rehabilitation program for employees over a three-year period has been made by the Consolidated Edison Company of New York. Where the problem is known, procedure is to have friendly talk with employee, refer him to medical department, and start rehabilitation along psychological and social lines. Continued drinking can result in suspension, disability retirement, or discharge. Of 135 employees who received final warning, 53 stopped drinking, the other 82 cases were reviewed by panel. Eighteen were returned to duty; 18 received retirement annuities; 37 received separation allowance; 9 were discharged. In all, 71 (52 per cent) of the problem drinkers were reclaimed. The company estimates that the average loss to the company due to absentee wage loss and inefficiency caused by alcoholism was reduced during the period from $134,250 to $65,450, a reduction of 49 per cent.

ALCOHOL STUDIES AT UNIV. OF CHICAGO

ILLINOIS. The Intercollegiate School of Alcohol Studies will be in operation at the University of Chicago August 25 to 30, 1956. Open to college students and their leaders; to faculty members, counselors, and religious and welfare workers in college, this school faces the problems of alcohol from two collegiate angles—the campus interests of students and their future as citizens, and the basic problems of alcohol in current society. A limited number of scholarships will be available. Address all correspondence regarding scholarships or applications to: The Intercollegiate Association, 12 N. Third St., Room 522, Columbus 15, Ohio.

SUCCESS FOR FIRST NURSES INSTITUTE

NORTH CAROLINA. The State's first institutes on alcoholism held exclusively for nurses were successfully completed at Raleigh on May 1-2, and at Charlotte on May 3-4. 143 nurses registered for one or the other of the two-day institutes. Considerable interest was shown by all nurses in the subjects covered, which included: etiological factors, incidence and symptomatology, course and treatment, principles of nursing care, the therapeutic community, prevention of alcoholism, and Alcoholics Anonymous. Many expressed their gratitude to the NCARP and the nurses' associations for sponsoring this educational endeavor. Through the knowledge and understanding they achieved at these institutes 143 nurses are now better equipped to administer to the needs of alcoholic patients. There is a possibility that the NCARP will repeat the institutes in 1958.

YALE SET FOR ANNUAL SUMMER SCHOOL

CONNECTICUT. The fourteenth annual session of the Yale University Summer School of Alcohol Studies will convene at New Haven on July 1 and continue through July 26. The NCARP has already notified as many of the qualified applicants for scholarships of their appointments as funds will permit. Lecturers at the Yale Summer School of Alcohol Studies will include specialists in various fields—medicine, religion, education, and public health. Informal discussion periods will follow many of the lectures, and specialized problems will be explored in the seminars.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

ALL of his many friends will be sorry to learn that Mr. John Ruggles, member of the Hospitals Board of Control and Chairman of the ARP Committee, has been on the sick list. Mr. Ruggles has been under treatment at N. C. Memorial Hospital for a heart condition. We had the opportunity to visit with him recently, and can report that we found him in good spirits and apparently progressing nicely toward recovery. We want Mr. Ruggles to know that we miss him and hope that by the time this word reaches our readers, he will be back home and able to resume some of his normal activities.

Busy Season Ahead

We are beginning what promises to be an extremely busy spring and summer schedule of activities for our ARP staff. Several major projects will demand much of our time and efforts during the next several months.

At this writing, we are looking forward to the two alcoholism institutes for nurses, which we are co-sponsoring in cooperation with state nurses' organizations. Identical institutes are scheduled for Raleigh on May 1-2, and Charlotte on May 3-4. Planning for the institutes has been a joint effort by representatives of the N. C. League for Nursing, N. C. State Nurses Association, N. C. State Board of Health and the NCARP. We have scheduled a top-flight panel of lecturers who will discuss a number of important and interesting subjects. These will include: "Principles of Nursing Care in Alcoholism," by Mrs. Avis Williams, Head Nurse, Division of Alcohol Studies and Rehabilitation, Medical College of Virginia Hospital; "Etiological Factors in Alcoholism," by John A. Ewing, M. D., Instructor in Psychiatry, University of North Carolina School of Medicine, and coordinator of Alcoholism Treatment and Research at N. C. Memorial Hospital, Chapel Hill; "Medical Management of the Alcoholic," by Thomas T. Jones, M. D., General Practitioner and staff member of Duke Hospital and Watts Hospital, Durham; "The Course and Treatment of Alcoholism," by Desmond P. McNelis, M. D., Clinical Director of the N. C. Alcoholic Rehabilitation Center, Butner. These are just a few of the subjects and speakers to be presented at the institutes. We believe that the remainder of the program will prove to be just as interesting and worthwhile.

This special institute on alcoholism was arranged in response to requests from numbers of nurses for an educational program on alcoholism designed exclusively to meet their needs. It is our hope that those who attend will look back on the experience as one of the highlights of their in-

(Continued on page 30)

VOL. VI, NO. 1 INVENTORY MAY-JUNE, 1956

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

You could have heard a pin drop after the psychiatrist made the cryptic suggestion: Why not

ACT DRUNK WHEN SOBER

AUTHOR'S NOTE

THE author wishes it understood that this article is not an attempt to advise anyone, alcoholic or otherwise, to "Act Drunk When Sober." In a treatment situation where psychiatric therapy is employed to give patients insight into their own needs and motivations this might be one of the suggestions offered for discussion under the leadership of the psychiatrist.

The reader should not expect to gain insight regarding his own emotional problems by reading articles of this nature. Self-treatment, without competent help, can be worse than no treatment at all.

The author hopes that some readers might benefit from reading this article to the extent that their knowledge of the precipitating factors involved in alcoholism might be broadened and that their understanding of psychiatric treatment might be deepened. The talk by the psychiatrist at the end of the article is not a verbatim account. It is added by the author as an impression of the understanding many patients accumulate under psychiatric care during an entire treatment period.

BY HORACE CHAMPION

TWENTY-EIGHT alcoholics—twenty-three men and five women—draw up their chairs in a three-row semi-circle before the psychiatrist for the daily group therapy sessions.

The psychiatrist settles back in his cushioned chair, crosses his legs, casually lights a cigarette and gravely contemplates the blue-gray smoke as it curls lazily toward the ceiling. There is a certain calmness, a serenity, about this doctor that seems to saturate the humid Spring air.

The small talk, the joking and tittering among the patients, the scraping of chairs on the floor, fades into a deep silence as the attention of each patient is inexplicably drawn to this person who is professionally trained to help them.

For fully ten seconds the room is filled with the heavy silence. If the doctor is aware that his patients are waiting expectantly he gives no indication of it. Unhurriedly, he takes a last, deep drag on his cigarette and very carefully crushes out the fire. Leaning forward now, his elbows resting on the arms of the chair,

hands clasped comfortably, he surveys the faces before him.

There is Tom B., a 55-year-old farmer who decided to come to the Center because, "I drank a fifth of liquor every day for the past twenty years, and it got so it didn't do me any good."

There is Jerry W., a six-foot-four, 220-pound good-looking giant of a man, less than 30 years old. His week-end benders had begun to extend through the following Mondays and Tuesdays. He had been fired from his job because of it. Evelyn, a very quiet, meek woman of 45, twists her hands nervously. In the previous group session, in which over-protection was discussed, she had become sick and had to run to the ladies' room, her hand cupped over her mouth.

In the group also are salesmen, truck drivers, a lawyer, the owner of a business doing over half-a-million dollar business annually, and a court reporter. Several are here for a second 28-day period of treatment because they had been unable to adjust to sobriety and had relapsed into drinking. One is here for the second time even though he has remained completely sober for over a year. He realized, he said, that after a year of sobriety he needed to readjust certain attitudes and feelings which were still causing him trouble in his relationships with others.

Seeking An Answer

Their social histories, their personality and intelligence tests, show wide social, economic, and personal differences. The common denominator is alcoholism. Each is only one drink away from a drunk which can lead to misery and trouble for himself and others. That is why they are gathered together in this curiously homogeneous group, seeking an answer to the common problem of living in a personally satisfying and socially acceptable manner without having to rely on the crutch of alcohol. What each wants to know is: How can I live without feeling compelled to take that first drink?

A man with a paralyzed leg does not throw away his crutch without a strong faith that he can walk without it. If no organic cause can be found for his paralysis he can be taught to have faith in his ability to walk without his crutch. He can be taught to walk alone.

Changing Thoughts And Feelings

So it is with the alcoholic. Researchers have failed in every instance to prove organic causes for alcoholism. They do know that alcoholics are recovering from the illness through certain readjustments in thinking and feeling—readjustments that can be accomplished with the help of persons such as the good doctor sitting before the group of alcoholic patients this bright Spring morning.

This morning, and every morning at this time excepting Sundays, the patients have seen a movie designed to help them uncover and recognize their own emotional troubles. The patients' social histories describe their personal, social, and economic background, but they only hint at the troubles that cause all the troubles. These are buried in the inner recesses of the mind, like little burrs under a horse's saddle, unseen, unrecognized as such, but real and painful enough to drive one to certain destruction unless they are removed or rendered harmless.

Psychiatrist's Job

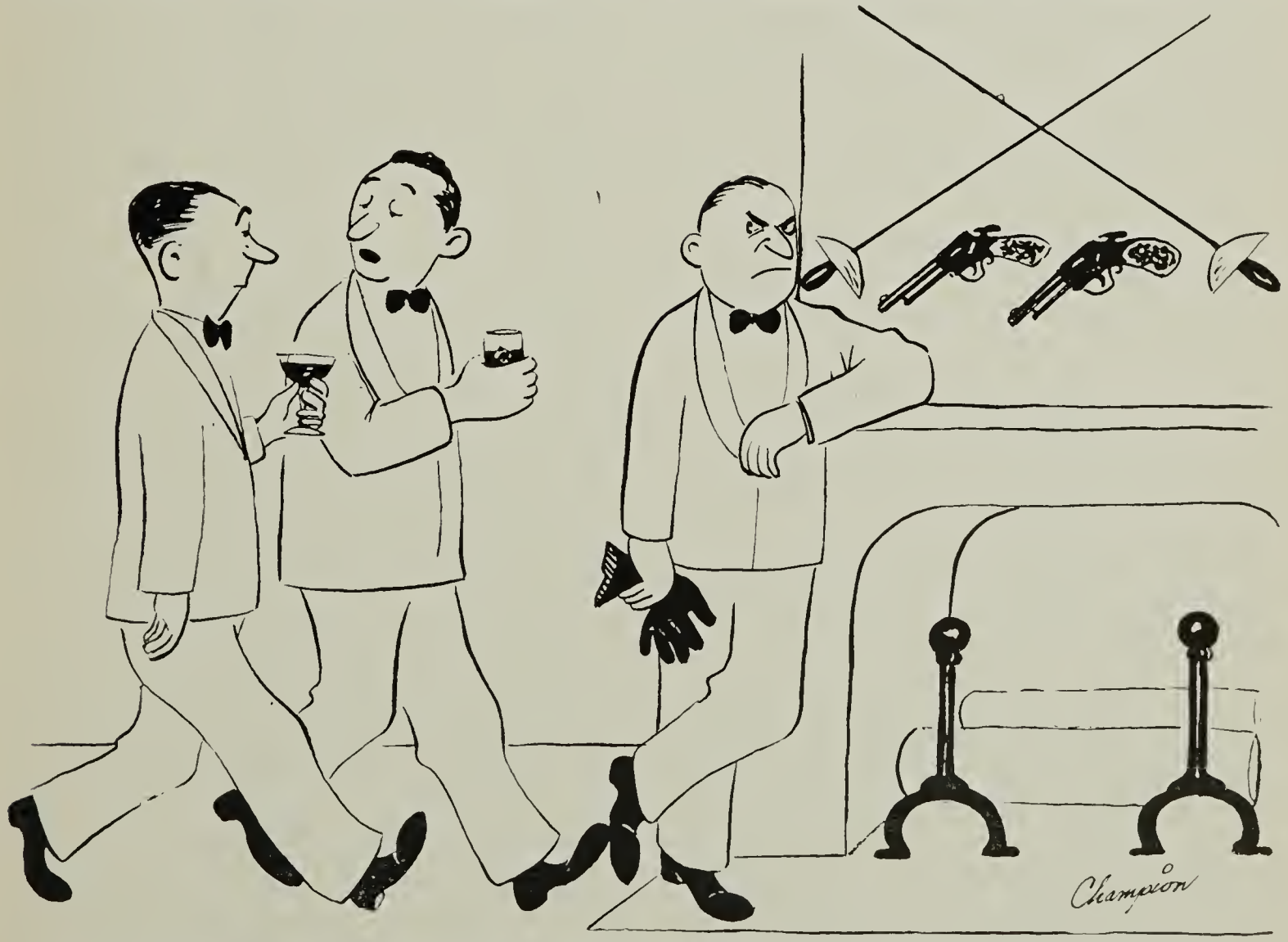
Helping the patient to remove as many of his emotional "burrs" as possible is the job of the psychiatrist. His job also is to help the patient accept and adjust to the pain of those

emotional burrs that are buried too deep in his personality structure for removal in group therapy. The desired goal of this mental reorganization effort is a higher degree of acceptance of self and others and a more mature intellectual and emotional reaction to life's problems.

Each group therapy session is an attempt to carry the patient a little nearer to that goal, to get him close enough so that he can attain it by himself. Most of the movies illustrating emotional problems do not have alcoholic characters. Instead, they develop migraine headaches, ulcers or hypochondria. They become slaves for others or they expect others to be slaves for them. After seeing a few of these movies and discussing them with the doctor, it is not difficult for the group to identify themselves with one or more of the film characters and to understand how the film actor might very well have developed alcoholism as a result of his emotional problems instead of some other symptom of emotional conflict.

In one of the films a young man is extremely shy with girls. He walks with a girl down a wooded path. They stop and as they talk he unconsciously hugs a tree instead of the girl. "What would have happened," the doctor asks, "if he had had a few drinks under his belt?"

Another film has as its main character a young man with a mother who refuses to let her son grow up and a wife who pampers him as if he were a young boy. He suffers from all kinds of imaginary ailments, using his hypochondria both as a shield against accepting mature responsibilities and as a token of resistance against being managed by his wife and mother. The group's discussion of this film is always a lively one because most alcoholics have this same problem to a greater or



"Be careful what you say and how you say it. He's been on the wagon for a week."

lesser degree. The only difference is that instead of being "sickly" all the time, alcoholics get drunk. This is something the patients can understand.

Each, according to his own experiences, describes to the group what might have happened if the film character got drunk instead of "sick." Most of them would have him "wear the pants in the family." He would openly express his resentment at being managed and take over, at least temporarily, the management of home and family. He might even "beat up" both his wife and mother. Or he would "run around" with other women, talk back to the boss, tell his wife to "shut up" when she started nagging, etc. His attitudes toward himself and others would change to a marked degree under the influence of alcohol. But the combination of his uncomfortable feelings and intoxication distort both the problem and his reaction to it. The pendulum swings too far in the other direction, and he discovers that once again he's in trouble.

Can't Blame Others

At this point the members of the group feel that they are not alone in needing treatment; it is a comforting thought to them—too comforting to some who grasp this opportunity to shift the blame for everything on mothers, fathers, or wives. But the skills of the therapist include handling this type of situation and he carefully interprets the attitudes of these patients in the light of their own neurotic needs as brought out by the films. Wives are neither on trial nor in a treatment situation; mothers and fathers did what they thought best for their children, and whether or not they were right or wrong is not the point in question. The end product is the patient and the immediate problem is to help him recognize his own inadequacies, however they were caused, and help him become a more adequate personality.

In discussion after discussion of the films the patients have been asked to discuss, "What would this neurotic film character have done in such and such a situation had he been intoxicated?" In every instance the patients agreed that he would have lost other psychosomatic symptoms like headaches, stomach pains, nervousness, etc., and would have felt himself to be, while intoxicated, a more adequate personality for meeting such problems as nagging wives, tyrannical employers, socializing, or sex.

Act Drunk When Sober

Now, this morning, the psychiatrist is ready to drop a psychological bombshell into their laps in the form of an explosive suggestion. Up to this point the discussion has been largely centered around the film characters, getting them drunk and speculating on their attitudes and behavior when intoxicated. The doctor will now apply his skills in a more direct manner.

"Why not act drunk when you're sober?" he suggests.

In the few moments of shocked silence that follow it can be presumed that at least some of the patients are receiving flashes of insight into their own personal reasons for using alcohol, that their own behavior when drunk matches the behavior of the film's actor when they got him drunk, that they used intoxication as the easiest and most convenient means for becoming, even temporarily, the kind of personality they wanted to be when sober. The old saying, "A drunk man's actions are the sober man's thoughts," comes to mind. It is not literally true, of course, on the conscious level of thought. But it is well known that

intoxication has a strong tendency to release emotional "thoughts" and desires which have been consciously repressed because they were *considered* dangerous or socially unacceptable. This is an important point in psychiatric treatment for alcoholic patients. Everything that we consider dangerous or socially unacceptable is not necessarily so, but the fact that we *consider* them so makes it true for us.

Fear Of Failure

An ambitious father wants his son to excel in everything. He is not satisfied with his son getting a two-base hit in baseball; it has to be a home run. The son does not quite make the honor roll in school, and the father wants to know, "What's the matter? You stupid, or something? From now on you'll spend two hours every afternoon studying your lessons." And so on, *ad nauseum*. Never quite living up to the standards set for him by his father the son finally gives up and doesn't even try. He has reached that stage, with help, where he does not consider himself capable of facing competition in any form.

To face competition is dangerous. He will be reproached if he fails to be the best. So he does not compete for that better job. Although he plays the piano well he will not help to entertain at the party—he *might* hit a wrong note and be laughed at or criticized. Because alcohol deadens self-criticism and inspires confidence it can be seen what a tremendous appeal intoxication might have for this type of personality. Chronic intoxication could be the easy way out.

A neurotic mother lives in constant fear that "something" will happen to her young daughter, either now or in adulthood. The girl cannot play with the other kids this afternoon; it's a bit chilly and "she might catch cold." She mustn't come in the kitchen while Mommy is cooking; "she might burn her hand on the stove or pick up a knife and hurt herself." In high school she mustn't go to the show with that Williams boy unless Mother or Daddy takes them there and brings them back. In college she must never go out with a boy friend unchaperoned and she must be in before 11 o'clock; college boys are wild and "what might seem to you to be an innocent little kiss could lead to unspeakable tragedy for you." Don't! Don't; Don't! It seems to the daughter that is all she has ever heard. Consequently she fears nearly everybody and nearly everything. She considers herself incapable of establishing friendly relationships or of taking care of herself in interpersonal situations.

To avoid being hurt she shys away from close friendships, spending most of her free time with her books or record player. But boredom, loneliness, and self-pity can become unbearable. She may find that alcohol temporarily drowns her fears about herself and other people. It's so easy to take a few drinks and escape from the shackles of her childish and warped feelings. Alcohol could become the usual crutch and alcoholism the destination.

Patients' Reactions

And so each of the 28 members of this group of people who have lost control over their drinking sits before the psychiatrist this morning and ponders the suggestion he has just offered: "Why not act drunk when you're sober?"

"Good Lord!" exclaims a male patient, "My wife would think I'd gone crazy if I hauled off and slapped her when I was cold sober."

"Don't you suppose she thought you were a little crazy to slap her when you were drunk?"

"I guess so."

"How would it make matters worse to slap her when you're sober?"

"I don't suppose it would. But I wouldn't slap her if I was sober. I never have. In fact I've never even thought about slapping her when I'm sober."

"Then why do you suppose you slap her when you get drunk?"

"I . . . I don't know. When I'm drunk I just feel like talking back to her. One thing leads to another, and the first thing I know I've hit her."

"Then drinking helps you to talk back to her?"

"Yes. She always wants everything to suit her. How I feel about things and what I want to do doesn't matter. I get fed up with it every once in awhile and well, when I'm drinking *her* feelings don't seem to matter to me. I do just what I want to do. I guess that's why I get drunk."

"So why not act drunk when you're sober?"

"You mean stand up for my rights, but be sober when I do it?"

"It might be worth a try. It'll take a lot of practice, of course, but it seems to be a step in the right direction."

Another patient breaks into the conversation: He's not going to be very easy to get along with if he goes around demanding that everything be done his way without any consideration for other people's feelings.

Third patient: That's right. If he tries to have his way all the time and his wife tries to have her way all the time, there's going to be trouble.

Female patient: There might be a little trouble to begin with, but when she finds out he means what he says I think she'd respect him for it and back down a little on her own demands.

Psychiatrist: That's interesting. Does anyone else have any comment on this?

Fourth patient: Hah!

Psychiatrist: I take it you don't agree with her?

No, I don't. If his wife is the controlling type she's not going to be all sweetness and light and say, 'Yes, darling. Yes, darling' when he stands up on his own two feet and tells her what's what.

Psychiatrist: What do you think she might do? Well, maybe we'd better ask her husband what he thinks she might do. How about it, Mr.?

First patient: That's just what I've been thinking about. She probably

WHAT IS "SUCCESSFUL" TREATMENT?

IT is unrealistic to establish arbitrary standards of "successful" treatment and no such standards have yet been established by the North Carolina program. Total abstinence alone is not the criterion of success for the type of psychiatric therapy we employ. Generally we would consider each individual patient's response to therapy in the light of his or her own constellation of personal resources and impairment.

Ideally, we might consider treatment successful when a patient has developed his inner resources to a degree that he can adjust to the realities of his environment in a personally satisfying and socially acceptable manner.

—S. K. Proctor
Executive Director
N. C. Alcoholic Rehabilitation Program

wouldn't believe it in the first place. She thinks I'm pretty weak when it comes to managing things, and I guess maybe I am, or was. When I used to handle the money I would sometimes go on a drunk around payday and come home without any money for paying the bills. So she's been handling the money for the past year or so. I'd just keep out enough for a fifth or two.

Psychiatrist: What would happen after you drank that up?

First patient: Oh, I'd get some more some way.

Psychiatrist: Did you ever get money for whiskey from your wife while you were drunk?

First patient: Sure. Lots of times If she wouldn't let me have it, I'd get it somewhere else.

Psychiatrist: And would she look after you until you'd sobered up?

First patient: Yes. She's pretty good about that.

Second patient: It sounds to me like she's not nearly so concerned with your drinking as she is with running everything.

First patient: She likes to run things, all right, but my drinking is the big problem right now. Sure, she said she was going to leave me if I didn't come here for treatment and stop drinking. But that's something I want, too. So I don't consider that 'running things.' There's one thing I am sure of and that is there'll be peace in the family if I can stop drinking.

Second patient: I bet I've stopped drinking a hundred times to keep peace in the family, and it never worked. My wife had to have peace on her terms, and I'd put up with that being watched every minute to see if I was going to take a drink, and being told what to do and when to do it, and made to feel like a red-headed step child until I just couldn't stand it any longer, and then I'd get drunk. Maybe things will be different in your case. I hope so.

Psychiatrist to first patient: Do you think things will be different when you go back home?

First patient: Yes, I think they will. I came here to learn how to stop drinking. And, by golly, I think I've learned something today. If I had tried to accept the responsibilities I was supposed to accept as a grown man years ago, and if I had worked harder at being the kind of person I wanted to be . . . if I had tried to do

ALCOHOLIC AL SAYS . . .

A hangover is when you wouldn't feel the way you do if you hadn't been drinking the night before.

Alcohol is what makes the world go 'round, and 'round, and 'round.

Intoxication is the ladder to those castles in the air. Watch your step.

Did you ever see a dream walking? Well, I did. A few days in the DT ward fixed up my vision just fine, though.

When everything begins to look rosy, shut your eyes; you might be bleeding to death.

When it takes two to tango you'd better just intermission.

If it takes four drinks to get you high, why try for outer space?

There's a time and place for everything. It depends on what you want. If it's sobriety the time is now and the place is where you are. Phone AA TODAY.

these things on my own without running to the bottle all the time for help, I wouldn't be here today. So from now on I'm going to try. And maybe I'll learn yet.

Psychiatrist: I think you're on the right track now. And since our time is running short I'm not going to ask for further discussion this morning. But I do want to make a few comments that might help to clarify some of the things we've been talking about.

Feelings And Attitudes

We've been talking about our feelings and attitudes toward ourselves and others and how our emotions influence our lives. Through our films and discussions we have tried to learn how we develop certain feelings and attitudes that can cause us trouble as adults. We have seen how we develop deep-seated feelings of guilt, hostility, anxiety and dependence and how various people handle sick feelings that interfere with satisfactory living.

One person gets rid of his uncomfortable feelings by nagging, criticizing, or belittling others. Another channels the energies of his sick feelings into fanaticism on one subject or the other. Some who seem unable to release the intense energy generated by their sick emotions "explode" so to speak from the pressure. Included in this category are people who develop ulcers, skin rashes, high blood pressure and many other symptoms of internal "explosions."

Others, like yourselves, may find that they can release these inner pressures—the built-up resentments, feelings of inadequacy, etc.—by getting drunk. When you're sober you can't work up enough courage to ask the boss for a raise, or you don't feel that you can carry your full load of responsibility at home or in church or in other activities. You don't feel that you can enter into the spirit of a social occasion, or you're all tense and worried and filled with a sense of self-pity, loneliness, and just plain boredom. We all know the easy way to overcome these uncomfortable feelings—just take a few drinks and they seem to disappear. There is a sense of well-being, a feeling of being more like the kind of person you *want* to be when sober, or a feeling of being able to do the things you want to do when sober.

This is what alcohol does for you. It does the same thing for the person who never loses control over his drinking. But his need for comfort, or his need for escape from the pain of living, is perhaps not as great as yours, and he does not lean too heavily on the alcohol crutch. What we are concerned with here is finding ways for *you* to learn to live without leaning on the alcohol crutch.

Setting Reasonable Goals

None of us can do all the things we would like to do, and none of us can be exactly the kind of person we would like to be. We must accept our limitations, and strive for goals that are within our reach. We must work toward worthwhile goals. No one can do this for us. The goal might be holding down a job or striving for a better one. It might be keeping the family together and building a home in which your children can grow happily. It could be taking an interest in an enjoyable hobby. It could be liking yourself or others a little better. Your goal could be any or all of these things. It depends on where your happiness lies. True happiness comes from the feelings within ourselves, feelings of love for others and being loved in return, feelings of accomplishment, feelings of confidence in solving problems.

For the alcoholic the difficulty in

achieving true happiness comes from feelings which are opposed to feelings of love, accomplishment, confidence, etc.—feelings which we have explored in our movies and group discussions. I hope that each of you by this time has recognized in yourself as you recognized them in the movies the particular feelings blocking your way to happiness. When these feelings are brought out into the open where they can be recognized, it is not too hard to face them. Nothing can be so terrifying as the thought of having to fight an enemy in the dark. And so I hope through our movies and discussions we have turned the light on in the arena. The conditions for fighting are a little better.

Now it is up to you as to whether you will fight the enemy or try to escape. The fight will not be over tonight or tomorrow or the next day. The fight will continue as long as uncomfortable feelings block happiness, and that could be a long time, a lifetime perhaps. But as we face each day with determination to *try* to think positively, to try to be a little more aggressive if we are not aggressive enough, to try to act more independently if we are too dependent, to try to express love when feelings of hostility or resentment arise, to try to get through this day without leaning on the alcohol crutch, we will find that our ability to do these things will improve. We will be on the road to happiness.

That is what I was getting at when I offered the suggestion: Why not act drunk when sober? Why not try to be the kind of person you want to be without getting drunk in order to think you're that kind of person? Why not try to do the things while sober that you invariably do when you're drunk? *If* you can be the kind of person you want to be when sober, there is no need to get drunk, is there? *If* you can do the things you want to do when sober, there is no need to get drunk in order to do them.

Growth Is Painful

Of course, this requires effort, strain, and some emotional pain. But all growth is painful, and we might as well accept the fact that we're not going to escape from all frustration and anxiety. We can learn to live with our emotions. We can learn to do something about our problems. The first and continuing step in this maturing process is to *try*. The second step is not to be discouraged by our failures. Rome wasn't built in a day, you know.

Think over your intoxicated behavior for a moment. What did you usually do when drunk that you wouldn't do when sober? Did you assert yourself as a more independent person? Did you express all the criticisms, the resentments, toward your wife, or mother, that you wouldn't (but wanted) to express when sober? Did your resentments

MATRIMONIAL TIDBITS

THE alcoholic was reciting his childhood experiences to the psychiatrist. "It was a peaceful home life," he said. "Anything my mother wanted to do, Pop let her do, saying she had a perfect right." He paused, then added thoughtfully, "She had a perfect left, too."

Jealousy: An emotion whose expression will assure the loss of the thing you are afraid of losing.—Anon

Incompatibility: In matrimony, a similarity of tastes, particularly the taste for domination.—Ambrose Bierce

get out of hand when you were intoxicated to the extent that you slapped your wife? Would it make matters worse if you did these things when sober?

I'm not suggesting that you haul off and slap your wife whenever you feel like it. I *am* suggesting that if this happens to be your problem, then why not *try* to stand up for your rights and assert yourself as a more responsible, more independent person, when sober? When you're sober you're not likely to slap her because you will have the control over your emotions that you don't have when intoxicated. But if you *try* and try again you will be able to get across to your wife eventually the expressions, the ideas, that you want to get across to her. You can be the kind of husband you want to be—without going overboard as you might do when intoxicated. In the process you might even learn to respect her ideas without feeling resentful.

Winning Friendship

If you happen to be the kind of person who "buys" friends when you're drinking, why not try to win them without throwing your money away? You can find plenty of people who will want to be your friends without expecting any reward other than your friendship for them. Alcoholics Anonymous is full of people who will be your friends if you will let them. All that they ask is your honest desire to maintain sobriety.

Do you invariably wind up in a fight, or in jail, when you're drinking? Do you resent authority so much that you cannot stand to be contradicted, or crossed, when you're drinking? If you do, then it's likely that you resent being ordered around by someone when you are sober. The only difference is: you don't do anything about it when you're sober. But you'd like to. I hope that those of you who have this behavior pattern when drinking recognize and can accept that your resentment of authority stems from being frustrated repeatedly by people in authority when you were very young. You learned to hate them. You are no longer children but this idea has persisted toward anyone in authority because authoritarians are people who make you feel incapable. You work hard toward perfection, and since you cannot achieve that goal you resent people who might find the slightest flaw in your work. Well, people in authority so far as your jobs, your duties, are concerned, are not really like that. They don't expect you to work yourself to death. You are the only one who expects that. So, why not try to relax a little, expect a little less of yourself, and I think you'll find that your employer doesn't expect so much either. But if he does—if he is a real slave driver—then why not *try* to tell him that if he expects you to work day and night he will have to pay you well for his encroachment on your time? Why not tell anyone who tries to make you do more than you feel that you can do that you are not willing to do that much. Why not *try* to stand up for your rights when you are sober? Try.

Of course, there are other types of people who have, or will, lose control over their drinking, but we cannot discuss all of them today. In the 28 days that you are here I hope that you will learn to know yourselves better. Know your limitations, but don't forget your goals. Think about your intoxicated behavior. It will teach you very much about the kind of person you really want to be. So, why not *try* to act drunk when sober?

Sobriety has helped me to appreciate so many things I used to take for granted.

WHY I AM THANKFUL TODAY

I AM just an ordinary sort of guy, the kind you meet on the streetcar, or run into at the corner grocery store, and after you have met me, you don't run home and tell your wife you've had an unforgettable experience. But, since coming in contact with AA, I find that I am truly and humbly grateful for so many things.

I am thankful today for the same things I used to take for granted; thankful that I have a home to go to and a roof over my head; thankful that I have a table to put food on, and thankful that I can enjoy a meal.

I am thankful that I have a bed to go to, and thankful for a night's sleep. I am thankful for the sobriety that has come into my life; thankful that I awoke this morning with a clear head and with the feeling in my heart that if I did my part today, God would do His. I am thankful for the love and affection of my wife. I am thankful that the eyes of my children reflect happiness rather than the terror which was there when I came home stinkin' drunk.

I am thankful for some of the nicer things in life that have come my way since I stopped buying liquor. I am thankful for the peace of mind and happiness that have come to me. The problems of life are still here, but I am thankful that I can face them without recourse to liquor.

I finally realize that there are only 24 hours in each day and that each man can eat only a certain amount of food. No millionnaire can get 25 hours out of a day, nor can he eat more than his stomach can hold. He can't put a fence upon the sun and he can't deposit those stars at night in a safety deposit vault.

That is why I am thankful. I am thankful because, except for a few carefully engraved bits of paper which are called dollars, *I am the richest guy in the world!*

—Dick C.
Robesonia, Pa.

ALCOHOLIC SAM, STARRING IN

AS HE THINKS HE MIGHT BE...



① AFTER A FEW DRINKS.. BUT...



② .. AS HIS WIFE MIGHT SEE HIM



⑤ ..AS THE CLERK MIGHT SEE HIM



⑥ ..AS THE BOSS MIGHT SEE HIM

North Carolina Library Commission
Raleigh, N. C.

THE SLIP THAT ALMOST WAS



③ ..AS HIS CHILDREN MIGHT SEE HIM



④ ..AS HIS MOTHER MIGHT SEE HIM



⑦ ..AS THE COPS MIGHT SEE HIM



⑧ WELL, NOT FOR TODAY, ANYWAY!



I CRIED YESTERDAY

It was a frustrated, self-pitying sort of cry,
just the thing you'd expect from an alcoholic.

ANONYMOUS

I HAD a dream last night about a four-year-old blonde. Her hair was in a pony tail, and she wore a brown and white tissue gingham dress with a full skirt. She was sitting on a log, swinging her Mary Janes and smiling at me.

This four-year-old is my daughter, but I hadn't dreamed about her in a long time. My dreams had been filled with howling nightmares, and my waking moments with terror.

I dreamed about her because I wanted to see her so much. I had thought I was going to see her yesterday. She and her sister and my mother were coming here to see me, a patient in the psychiatric ward in the N. C. Memorial Hospital at Chapel Hill. I thought I would ride among the dogwood-lined streets of Chapel Hill with my family, and, like I did last Sunday, enjoy the bright beds of azaleas. I love Chapel Hill. I spent many happy days here as a student.

Feelings Boil Over

Then I learned from my doctor that my family had been, and they were not allowed to see me.

That's when I cried inside. Afterwards, my frustrated feelings boiled over, and I cornered my doctor.

"Why can't I see my family?" I demanded belligerently.

"I'm not punishing you," he answered.

I thought of a scene in a film I had seen here, a film for alcoholics made here in Chapel Hill with personal friends of mine in the cast. In the film, the emotionally immature leading character is trapped in a cell of his over-dependency on his mother. When he rebels, Bang! Down fall the walls for a time, but later he runs back to the cell of his own accord—trapped by his own feelings of inadequacy.

I was acting like a child myself. How can I plan a happy life until I can grow up?

I managed to get myself in hand a little. I made a shopping expedition, accompanied by another patient who needed the walk also. I bought some walking shoes and a small bag. I wrote a letter to my other daughter, who is an independent twelve, and told her how much I loved her. I worked in occupational therapy on a copper plaque of a rose, which might be a gardenia, but it is a rose to me because roses are my hobby, and in my yard at home they are beginning to bloom.

I got through the day.

Today, I have taken a walk, tried to help other patients to help themselves, written a few "thank you" notes, and gotten tired. I realize I must live with today if tomorrow is to come for me.

Replace Anger With Love

I must replace my childish angers with Love—Love that expects no reward. In that way, I can look forward to a mature and happy existence. An AA sitting by my bed at the convention where I got drunk eleven months ago today gave me courage at that time to believe that I could arrest my alcoholism as she arrested hers. Since then, the help and love of my AA friends have helped me.

But it isn't enough. I must grow up. I am learning—after three weeks in this hospital—to have a little more faith in myself so that I can improve my character and try a little bit at a time to banish resentments and self-pity. The sixth step in the AA program is a hard one. The quality of my sobriety is indeed more important than its quantity, and by faith in the essential goodness within me I can learn to banish my fears and "take it easy." I must solve my own problem in the final analysis, even if I make mistakes.

I think I'll go home soon.

KANSAS' Commission on Alcoholism

Here is a young program, active in the fields of education, limited counseling, and research.

BY LEWIS W. ANDREWS
EXECUTIVE DIRECTOR

THE Kansas program on alcoholism is one of the younger state programs, having been established in 1953. The establishment of the State Commission on Alcoholism represented a public health approach on a state-wide basis to the existing problems of alcoholism. In 1953, members of the Kansas Legislature, recognizing the numerous problems resulting from alcoholism and the need for a program of study and research, education and rehabilitation, passed legislation establishing the Kansas State Commission on Alcoholism.

The five member Commission, appointed by the Governor, is by law composed of two medical physicians, two alcoholics who have been recovered for two or more years and one attorney. Members serve without remuneration other than necessary travel expenses to and from monthly meetings of the Commission. The members of the Commission are responsible for establishing policies and for the employment of an Executive Director who has the responsibility of carrying out these policies.

The duties of the Commission as assigned by the Legislature are (1) Study of the problems of alcoholism; (2) Education on alcoholism; (3) Treatment and rehabilitation of alcoholics; (4) Research into factors leading to alcoholism.

Appropriated Funds

The State Legislature appropriated $25,000 to the Commission for the fiscal year ending June 30, 1954; $50,000 for the year ending June 30, 1955; $50,728 for the period ending June 30, 1956 and $50,823 for the year ending June 30, 1957. All funds appropriated come from the county and city alcoholic liquor control enforcement tax fund. The present appropriation represents about 5% of the total amount collected from this tax.

The Commission employed the present Executive Director in October, 1953 and opened its office in Topeka at that time. Initial activities were directed toward determining facts about alcoholism problems in Kansas and about existing facilities

for treatment and rehabilitation. Emphasis has been placed in gaining the interest of various individuals, groups and agencies interested or active in the field of alcoholism (physicians, clergymen, social welfare directors, mental hygiene clinics, A.A. Groups, law enforcement officers, etc.) Considerable time is still spent in maintaining cooperative relationships with these individuals and agencies.

Meeting The Obstacles

This "ground work" was perhaps more important in Kansas than in other states. With a long history of prohibition, followed by repeal, it is understandable that there would be considerable feeling prevalent in regard to alcohol and alcoholism. It should be stated, however, that in recent years there has been an increasing tendency in Kansas to recognize the alcohol problems and to develop constructive programs to meet the problems involved.

State-Wide Survey

In August, 1954, a state-wide survey of the incidence of alcoholism and facilities for treatment and rehabilitation of alcoholics was completed. The services of a private, non-profit health and social research organization were engaged to conduct this study. The study disclosed that there are a minimum of 21,000 problem drinkers in Kansas. This is a rate of 15.8 per one thousand adult population. Some of the social and economic characteristics of the alcoholics in Kansas, as disclosed in the study, are as follows (1) 87% are male; (2) the median age is between 45 and 49 years; (3) 64% are married; (4) 39% have dependent children; (5) 52% are in the middle or high income groups.

In 1955 a study of the consumption of alcohol among high school students in Kansas was made in cooperation with the Department of Sociology of the University of Kansas. This study was made possible by a grant from the Mrs. John S. Sheppard Foundation of New York. The results will be available in the very near future.

From the time of the Commission's establishment in October, 1953, emphasis has been placed on education in regard to alcohol and alcoholism. All available media of communication have been used to present the facts about alcohol and alcoholism to the people of Kansas. This has consisted of radio and television programs, distribution of literature, state conferences, speeches, institutes for specific groups, and personal contacts.

Monthly Publication

We publish a monthly publication, "The Key," which has a circulation of approximately 5,000. "The Key," which is available to any interested person, presents scientifically accurate information on alcoholism.

The "Jayhawk Review," with a circulation of approximately 3,000, is a bi-monthly publication of the Commission designed for distribution to professional persons. The publication consists of or includes material from "Alcoholism Treatment Digest" and other scientific journals.

Literature Widely Used

Pamphlets and other literature have been used extensively throughout the state as have films, public speeches and our own factual booklet entitled, "Alcohol and Alcoholism."

Work with the schools has been confined to high school level. Programs are planned and developed for local high school groups at the request of the principal or other faculty member. Work with the elementary and junior high school students is done through the state department

of public instruction.

In December, 1954, the First State Conference on Alcoholism, jointly sponsored by the State Commission, University of Kansas and other co-operating groups, was attended by several hundred interested persons. The Second State Conference will be held at the University of Kansas, June, 1956.

One-day institutes have been held for social workers, law enforcement officers, and judges. During the coming year, two one-day institutes for clergymen will be held.

Scholarships have been provided to several individuals to attend the Utah School of Alcohol Studies and the Yale Summer School of Alcohol Studies.

Two information centers were established ouside of Topeka, one in a metropolitan area and the other in a rural area. Initially these centers were geared to provide educational services. Gradually the counseling services assumed greater importance. The metropolitan center eventually formed the nucleus for the establishment of a rehabilitation center.

In-Patient Center

In October, 1955, the Commission established a 12-bed, in-patient rehabilitation center in Wichita, Kansas. The full-time staff consisted of a psychiatric social worker, psychiatric aide, cook and a clerk. A neuro-psychiatrist, a counselor and a psychiatric social worker were on the staff on a part-time basis.

Patients were admitted only on a voluntary basis and their application for admittance had to be accompanied by a physician's statement that the patient did not need active medical care. Any alcoholic needing intensive medical or psychiatric care was first









referred to his local family physician and/or general hospital. Acutely intoxicated and psychotic patients were not accepted since the Center did not have facilities, nor staff, to handle such cases. The Center offered board and room, recreational facilities, casework services for the patients and families, structured and unstructured group therapy sessions and vocational guidance. A fee of five dollars per day was charged for the services. For patients unable to pay the fee at the time of admission, a deferred payment plan was arranged. A weekly A.A. meeting was held in the Center and the patients were encouraged to attend if they so desired. An important part of the program at the Center was the casework services to families of the patients. Relatives were helped to achieve an understanding of the problem, and also helped to develop a more understanding and helpful atmosphere for the alcoholic to return to, after discharge from the Center.

The program of the Center tried to help the alcoholic achieve some understanding of his problem, help him in his re-socialization process and to help him to keep seeking help. At time of discharge, patients were encouraged to seek help from physicians, psychiatrists, A.A. Groups, ministers and other agencies in their local communities.

Staff Attitudes

Emphasis was placed at the Center on the attitudes of staff members. We believed that it was very important for the alcoholic to recognize that the Center was one place where people accepted him, and where people were really trying to help him.

One idea behind the Center was to



provide a bridge for persons emerging from hospital treatment for acute alcoholism in their return to every day life. In cases where there was a turbulent home atmosphere in alcoholism, we felt it was especially desirable that these individuals were not thrown back to their problems at once.

Treatment Results

During the six months the Center was in operation, fifty-five patients were admitted from various areas of Kansas. Referrals were made by hospitals, physicians, ministers, families of alcoholics, social welfare departments, law enforcement officers, judges and A.A. Groups. More than half of the patients admitted to the rehabilitation center have shown improvement. Forty per cent have maintained their sobriety, 25% have shown definite improvement and another 20% have shown some improvement. Fifteen per cent have shown no improvement.

We expect to maintain contacts with discharged patients for a period of three years. In another year or two we will have more definite data for the purposes of evaluating the success or failure of the program at the Center.

Economy Move

Due to a general economy move at the 1956 session of the State Legislature, funds were not appropriated for the continuation of the rehabilitation center. A local non-profit group in Wichita, however, was formed and has taken over the operation of the Center on a local basis.

Although it is too early to definitely evaluate the success of the Center, we do feel that the value of such rehabilitation programs is beyond question. This has been fully demonstrated in other states. We believe that through education, rehabilitation, and research that alcoholism may ultimately be prevented. We don't feel it's wise to leave out any of them. Naturally we are hopeful that the next session of the State Legislature will appropriate the necessary funds for the re-establishment of a rehabilitation center.

Our present and future program in Kansas is restricted through legislative action to education, limited short term counseling with alcoholics, and some study and research. The information center in the rural community will continue its educational and counseling services on a local level. The State Commission will continue to use all media of communication available to present to the public information on alcohol and alcoholism. Short term out-patient counseling will be available at the Topeka office on a limited basis. Study and research will be conducted in so far as limited funds permit. Projects will be carried out in cooperation with state universities and local and state medical schools.

Begin at once to live, and count each day as a separate life.—Seneca

Three Men Are My Friends:
He that loves me, he that hates me, he that is indifferent to me. Who loves me, teaches me tenderness. Who hates me, teaches me caution. Who is indifferent to me, teaches me self-reliance.—Panin

It is practically a law in life that when one door closes to us another opens. The trouble is that we often look with so much regret and longing upon the closed door that we do not see the one which has opened.

Unhappiness: Not knowing what we want and killing ourselves to get it.
—Don Herold



I Was a Schoolteacher, But . . .

I COULDN'T TEACH MYSELF TO DRINK

BY MARY C.
CHESTER, PENNSYLVANIA

I TAUGHT school for fifteen years, but I was never able to teach myself how to drink.

Eighteen months ago I was confused, resentful, lonely, morbid, unreliable, unstable, remorseful, and unhappy. I was unwilling and unable to face issues. Today, I believe I am serene, happy, contented, honest, reliable, and friendly.

Eighteen months ago I was full of uncertainty, fear and discontent. Today, I welcome the sun in the morning, the promise of a new day. I appreciate the telephone call from a friend, and even enjoy the birds in

the back yard.

The organization of Alcoholics Anonymous has been the reason for this wonderful change in attitudes. A fellowship of men and women who share a common problem—my problem—alcoholism, has shown me how to accept this disease and live with it.

For the first time I am no longer struggling alone, making and breaking promises to others and myself; for I have found haven in a group of people who realize and understand because they, too, have suffered as I. They not only want to help me; they know how.

AA does not solicit membership, but when one realizes that alcohol has made him or her powerless, help from an AA member is as close as the nearest phone. There are no fees or dues. An honest desire for sobriety is admission.

I have learned that I can remain sober 24 hours at a time. I no longer tremble at the fact that I won't be celebrating the holidays in the future as I have in the past—for the past is behind me; I cannot undo it. The future is too uncertain, so why worry about either of them?

Today is all-important. It is today with which I am concerned. It is today that I want to be sober.

MENTAL HEALTH QUOTES

TO keep more of us mentally healthy, we all should practice more tolerance of differences, more trust, less suspicion, hate, and fear. Intolerance, hate, and fear can create doubt and insecurity, which help push people to mental breakdown.

—Dr. George S. Stevenson in *Today's Health*

ANY person who is to develop a good attitude toward other persons and relate himself properly to them must evaluate himself sensibly and must coordinate and integrate reasonably well the conflicting motives within his own life. In other words, he must neither feel defeated and hopeless and frustrated. He must have the joy of accomplishment toward self-initiated or accepted goals and of approval and commendation of others of his kind. He must continually be, on the whole, successful in his living. He must have some failure but more success.

—Laurence Spurgeon McLeod in *Mental Health In the Home*

OFTEN people who feel that the world is bad, that everyone is against them, are expressing a discontent more with themselves than with the world. They may be suffering from a lack of recognition or appreciation. They have perhaps set unrealistic standards for themselves, and their complaint against the world is the nature of an alibi for failing to achieve those standards. They are like the boy who won't play unless he can be captain.

Arnold A. Hutschnecker, M. D. in *The Will to Live*

IF a person does have a feeling of personal unworthiness, it does not present a hopeless situation. There is help for him. For a person to feel unworthy and inadequate to meet the situations of life is an indication of some sort of inner conflict or contradiction. An inner conflict means that two or more deep urges in his personality lead to contradictory and perhaps mutually exclusive behavior.

—Laurence Spurgeon McLeod in *Mental Health in the Home*

It's easy to admit drinking's got you licked. I've done it a thousand times.

ADMIT or ACCEPT?

ON many occasions during my long fling at imbibing, I admitted I was licked and wanted to do something about it. But not until I accepted the fact that I could not take that first drink was I successful in licking it.

So I can safely say to admit that you are powerless over alcohol and you want to do something about it is not enough. It is the first important step toward recovery, but until you reach the stage of complete surrender and actually accept the fact, you haven't got a chance.

I am now 67. I have been a travelling salesman all my adult years, and I still am. I started heavy drinking at the age of 18 and did not stop until, with the help of the Higher Power and AA, I was past 60—42 years of hard, steady, two-fisted drinking.

How many times during those 42 years of nightmares, hangovers, DTs, blackouts, and all the rest of the horrors that go with this kind of drinking, did I look into the mirror and say, "You so-and-so, why don't you do something about it? You're licked."

That kept up until one day AA came into my life. I went to eight meetings a week—seven evenings and one on Sunday afternoon. This continued for many months, and all this time I admitted I was powerless over alcohol and sincerely wanted to do something about it.

Then, on March 6, 1950, I went my first 24 hours without a drink. I had finally accepted the fact that I could do without it.

For me, the first year was not easy. But each succeeding year the tension has lessened until now, the start of my seventh year of continuous, serene sobriety, it is easy as long as I keep on accepting the fact that I do not need that first drink.

As they tell you in AA, there are no rules or by-laws. Each and every one of us does it our own way. This was my way, and in my opinion, anyone who accepts the facts and has faith in complete surrender cannot have any trouble.

—Jerry H.
New York City

MORE ABOUT SLIPS

Common pitfalls often are responsible for triggering an alcoholic's relapse.

BY HUGH S. THOMPSON
SEC'Y, COMMITTEE ON ALCOHOLISM
PROTESTANT EPISCOPAL DIOCESE OF S. C.

QUESTION: What, in your opinion, is a slip?

Answer: My understanding of a slip, when viewed in its simplest terms, is a relapse into the use of alcohol on the part of an alcoholic who has had a period of sobriety.

I can offer here no more than one man's impressions, and they are not original with me. They have been absorbed, however, from the confidences of a number of men and women who floundered in and out of AA for sometime before finding a satisfactory arrestation of their alcoholism.

But first I think we must eliminate some cases where there are very severe and insurmountable physical and mental complications. The alcoholics involved need medical, psychiatric or institutional help—and sometimes long-term care or humane custody.

As for the general run of slips and their causes, I believe them to be typical, varying in pattern and significance somewhat from individual to individual. The pitfalls involved should leave none of us in doubt that alcoholism is a sickness involving the total personality.

Some Of The Pitfalls

Some of these pitfalls, as I see them, are: Some of us come to AA with stubborn reservations. These often delay our reaching our particular 'bottoms.' We really continue to follow the old pattern of 'going on the wagon.' This is often accompanied by futile promises to self and others and unwittingly-inspired secondary ends. We have our angles such as the hope of impressing the boss, or retrieving a lost job, wife or broken home, or some other dire *consequence* of our illness. We remain plagued by other self-deceptions such as: we are going to sober up for the sake of wife, children or others. We

have not yet learned that we may only find and maintain genuine sobriety for ourselves first.

Emotional conflicts and confusions of long standing blind us to the 'cause and effect' equations of our abnormal drinking. We have lost our insights into our limitations. We do not know how to apply the principle of 'Take It Easy.' We think, plan and live at a frenzied pace that leaves us exhausted and vulnerable to the first fatal drink. Similarly, we often become overwhelmed by worry that becomes intense anxiety. The emotional pressures, if not resolved, become so acute that, like a fellow in the throes of kidney colic, we are willing to pay any price for relief through alcohol NOW!

Sometimes we have spells of despair or depression. These are usually accompanied by the deceptive mental reservation that 'one drink can't possibly hurt us.' Sometimes the underlying emotion is extreme exhilaration. We just must celebrate. But we are always going to celebrate only a little bit.

At times we become submerged in chronic self-pity, remorse, jealousy, or resentment. The resulting tensions add up to capitalized FEAR! This is the so-called dry drunk. If we fail to get on the beam, we invariably find ourselves in the same old squirrel cage of 'one drink is too many and a thousand not enough.'



Sometimes we are prey to our mental reservations, even when we have no conscious pain or need for escape. We are plagued by a normal drinking complex, which is particularly treacherous in periods of relative well-being. Somehow, some way, according to this recurring obsession, we are going to recapture our control over alcohol, to re-learn how to drink as we once did, to find the lost glass crutch upon which we once leaned. One of the most seductive aspects of this delusion and our enslavement to it rests upon the fact that, on the rarest of occasions, we can still drink and stop or control the situation.

Just One Drink

The delusion is magnified and intensified by these rare successes. We try to drink again and, Boom, we are off to the races once more. Some fellow in *The Grapevine* has pinpointed these mental reservations thusly: "We hear in AA we are just one drink away from a drunk. I prefer the way a friend of mine puts it: 'We're just one think away from a drink.' "

Sometimes we are intense in initial enthusiasm about sobriety in AA and fail to level off emotionally. We just 'poop out.' We become discouraged and fail to persevere. Then, we often drift. We have no need for alcohol today. We are sure we are not going to drink again. Or at least we are sure our drinking is not going to get out of control again. We become overconfident and cease our search for humility. Under these kinds of circumstances it is easy to take that first fatal drink.

A slip can also result from the unwitting use of medicines or substances other than beer, wine, whiskey, rum

or gin, which contain threatening percentages of alcohol nonetheless. Slips may result similarly from uninformed or deliberate resort to narcotics, sedatives, barbiturates or bromides. Most of us are supersensitive to the after effects or hangover discomforts of these pain killers. These can lead, in some instances, to further dependence upon narcotics, sedatives, etc., or to a so-called 'goof ball' problem. Even though these drugs may not necessarily lead to such a problem, they can pull the trigger on our compulsion to drink.

Lopsided Approach

Sometimes we slip because, like many other folks, in the search for relief from personal extremity, our approach to the AA program is lopsided. Some minimize the spiritual side of the program while others go to the opposite extreme of going overboard spiritually and ignoring the rest of the program. In either event we are neglecting to develop an open mind toward acquiring insight and failing to take action calculated to avoid the above pitfalls. Our welfare requires both the acceptance and application of knowledge that can help us. Such knowledge, however worldly its source may appear, whether in the realm of proper diet, mental hygiene, or the medically prescribed use of tranquilizing drugs, comes from the same source. And this source is God.

Pray For Wrong Things

Perhaps we pray. Yet, like many others, we often pray for the wrong things. We pray for what we want rather than for what we need most. Our prayers are often bargain prayers, promises to do this or that *if* the Deity will only grant us relief from our immediate pains. We often pray for relief from the consequences of our sickness rather than from the sickness itself. We usually neglect to pray for this grace to accept the facts of our alcoholism. Frequently, in any or all of these crises, overconfidence, indifference, false pride or ego prevent our bringing our difficulties out into the open, where other persons can help us before we take that first fatal drink.

Program Pointers

(Continued from page 4)

service professional education.

During June and July, we are again conducting Summer Studies on Facts About Alcohol in five of the teacher-training colleges in the state. The good attendance at previous summer schools plus the continued interest and cooperation of the colleges' administrations has prompted us to continue these educational courses for teachers. Participating colleges include East Carolina College, A. and T. College, Fayetteville State Teachers College, North Carolina College, and Appalachian State Teachers College.

Purpose Of Schools

Last year, a total of 160 public school teachers, both white and Negro, were enrolled in our Summer Studies. This summer we are hoping for an even larger enrollment. Teachers realize their responsibility under state law to present factual, scientific information about alcohol subjects to public school students. It is our purpose to provide them with the tools—an adequate personal store of information plus a thorough knowledge of latest teaching materials and techniques—to enable teachers to meet their responsibilities. Judging by the comments of many teachers who have completed our two-week

courses, this purpose is being accomplished. Teachers tell us that they find the job of alcohol education is much easier and less anxiety-provoking for them after attending Summer Studies on Facts About Alcohol. For this reason, we regard our summer courses as one of the most important and rewarding areas of our educational activities.

We are pleased that we have been invited again this year to participate in the Kanuga Conference on Alcoholism, to be held June 8-10 at the Episcopal summer assembly grounds outside Hendersonville, N. C. The conference is sponsored by the Department of Christian Social Relations of the Episcopal Church. Our good friend, Rev. Joseph Kellerman, Rector of the Church of the Holy Comforter in Charlotte, is director of the Conference. Miss Lytle, Dr. Kelly, and I will appear on the program.

MENTAL HEALTH CREED

1. **I believe in God, and with His help I will make my life significant.**
2. **I will adapt to life immediately, completely and gracefully.**
3. **I will work, rest, exercise, play—every day.**
4. **I will work at a worthwhile job.**
5. **I will avoid undue fatigue.**
6. **I will laugh more every day.**
7. **I will form good habits of living, thinking, acting, speaking, and feeling.**
8. **I believe: that self-pity, suspicion, envy, jealousy and revenge are useless sentiments. That loyalty, courage and kindness are dependable sentiments; in them I will put my trust.**
9. **I will discount harmful emotional urges, avoid emotional orgies, and keep away from emotionally undisciplined people.**
10. **I will face facts, discount my likes and dislikes, and cultivate an objective point of view.**
11. **I will know myself, accept my liabilities, and cultivate my assets.**
12. **I will make clear-cut decisions and abide by them.**
13. **I do not expect to get precisely what I want in this world. I will not kick against the pricks of life. I expect trouble and have accepted inevitable difficulty, that I may be free to accept opportunity unhandicapped by a sense of difficulties.**
14. **I know that fear, anxiety and worry cannot hurt me. They threaten to destroy, but they possess no weapons other than the ones I give them. Even though afraid, anxious, and worried, I shall continue with my usual activities, knowing that fear is the normal stimulus to courage.**
15. **I choose to see the good aspects and meanings of life. I do not deny that ugliness and evil exist; I do not overlook them, but having seen then I choose to look for the good.**
16. **I know and will help others to remember that humanity is a vast reservoir of love, courage, helpfulness, strength and ability. I shall draw on it without limit to help others and myself.**

—William M. Terhune, M. D. in "Emotional Problems and What You Can Do About Them."



Books of Interest

ALCOHOLISM - ITS SCOPE, CAUSE AND TREATMENT

$3.00

By Ruth Fox, M.D., and Peter Lyon

New York: Random House

DR. FOX is a well-known therapist of alcoholism who brings a psychoanalytic viewpoint to the problem. She is well qualified to write a book of this nature and has done a commendable job.

The first section of 70 pages consists largely of a factual account of alcohol, its history, its effects upon individuals and upon society, and so on. A simple account of relevant psychoanalytic theory is included which is well within the intellectual grasp of the intelligent layman.

Clinical Account

The next section is a clinical account of alcoholism with some good psychiatric histories. It includes quite detailed consideration of classification of excessive drinkers, phases of alcoholism and some mention of current research.

Next, treatment is discussed. The AA movement is described, the various forms of psychotherapy are mentioned and Dr. Fox goes on to say, "Under ideal conditions, analysis would always be the psychotherapy of choice." Fortunately, she elaborates this sufficiently to enable the reader to realize that "ideal conditions" are infrequent.

Dr. Fox is known as a devotee of Antabuse (disulfiram) and she describes its use enthusiastically. However, this reviewer doubts her wisdom in stating, "Anybody can take it so long as he understands what he is taking and realizes that if he drinks alcohol on top of it he may get seriously sick." She talks about its "proper administration" and emphasizes that it is only an adjunct to psychotherapy, even suggesting that its prescription might well be limited to physicians who are prepared to offer psychotherapy as well. I can only hope that physicians will note the implied warning in the latter remark and will not look upon Antabuse as a treatment in itself. Certainly we have seen from time to time "borderline" patients who have developed psychotic episodes while receiving Antabuse treatment alone. The patient's usual "escape route" via drinking has no longer been available to him in time of stress.

The last few pages of the book list sources of help by States. This is up-to-date and useful.

The book can be recommended to all laymen interested in alcoholism, alcoholics, alcoholics' relatives, social workers, ministers and physicians, provided the latter are not looking for actual therapeutic guidance. Anyone who reads it through should end up with a more sympathetic and fuller understanding of the alcoholic from the dynamic viewpoint.

—John A. Ewing, M.D., D.P.M.
Coordinator, Alcoholism Treatment Services
N. C. Memorial Hospital
Chapel Hill, N. C.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
300 E. Northwood St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

North Carolina State Library
Raleigh

JULY-AUGUST, 1956

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Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Parable Of The Twelve Steps

What About The Kids?

What Makes People Happy?

Cause, Effect and Treatment

Michigan's Alcoholism Program

Sobriety—Step By Step

News From 'Round The World

Program Pointers

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

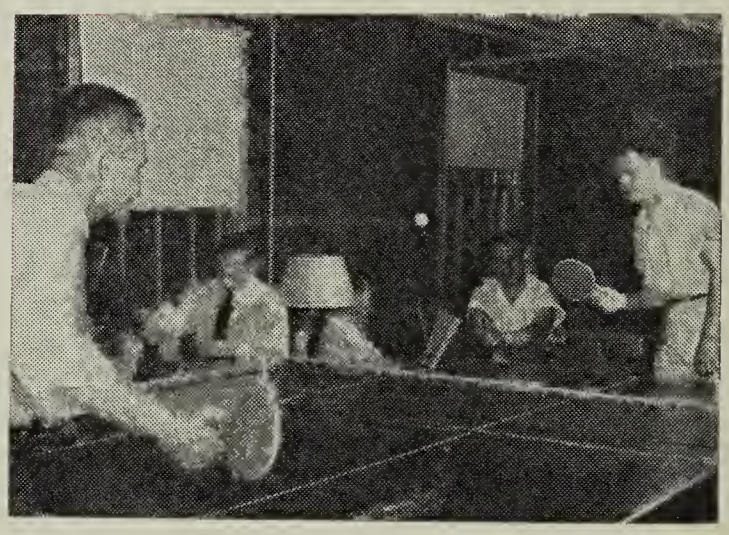
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

DESMOND McNELIS, M.D.
Clinical Director

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INVENTORY

VOLUME VI NUMBER 2

JULY-AUGUST, 1956

RALEIGH, N. C.

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News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

SAN FRANCISCO HAS HIGHEST ALCOHOLISM RATE

SAN FRANCISCO. Two Yale University researchers have tagged this West Coast city with the dubious distinction of having the highest alcoholism rate among the nation's big (over 100,000) cities. According to Mark Keller and Vera Efron of the Yale Center of Alcohol Studies, San Francisco showed a rate of 4,190 "alcoholics with complications" for each 100,000 adult population. The same statistical study showed that Charlotte, N. C. (population 134,000) had the lowest rate.

NEW N. C. AA DIRECTORY NOW AVAILABLE

NORTH CAROLINA. The fifth edition of the Directory of Alcoholics Anonymous Groups in North Carolina has just been published. It lists all AA Groups in the State together with locations, meeting times, Post Office boxes and telephone numbers. Copies of the Directory may be had free by writing P. O. Box 5643, Raleigh.

REHABILITATION COUNSELING COURSE OFFERED AT N. C. STATE

NORTH CAROLINA. N. C. State College announces a graduate training program in rehabilitation counseling. Approximately one to two years is required for completion leading to Master of Science degree or the Master's degree in the professional field. A number of graduate scholarships ($1,600 for the first year of graduate study, renewable for a second year) have been made available by the Office of Vocational Rehabilitation. The demand for rehabilitation counselors is increasing sharply. The State-Federal Rehabilitation program alone requires over 100 per cent increase, and many job opportunities will be available in other agencies or institutions, both private and public. Applicants for admission to the training program must meet the admission requirements of the Graduate School of N. C. State College. For detailed information about the training program and the graduate scholarships which are available for full-time graduate students, write to: Dr. Roy N. Anderson, Head, Department of Occupational Information and Guidance, School of Education, N. C. State College, Raleigh.

VADE MECUM USED FOR AA RETREAT CONFERENCE

NORTH CAROLINA. A three-day retreat conference for AA members was successfully held at Vade Mecum, the Summer Camp and Conference Center of the Episcopal Diocese of North Carolina, in June. Located in the mountains of Stokes County, Vade Mecum furnished facilities for play, worship, meditation, AA meetings, scientific discussion of alcoholism, and good food and housing. The Episcopal Church will offer these facilities and services again next summer to AA members of all denominations. Total cost to each member this summer was $10.50. Persons interested in attending next year's conference should write: The Rev. Edwin B. Jeffress, Jr., Box 1792, Greensboro, N. C.

Personality Sketches

DESMOND McNELIS, M. D.

Clinical Director
Butner State Hospital

This well trained, personable young psychiatrist directs treatment procedures at the Butner Hospital and keeps a steady hand on the treatment wheels at the ARP Treatment Center.

QUALIFIED psychiatrists are scarce as hen's teeth these days. That's one reason the ARP and Butner Hospital were fortunate in having Dr. Desmond McNelis around to step into the clinical directorship of both the Butner State Hospital and the Alcoholic Rehabilitation Center, left vacant when Dr. Lorant Forizs moved to Florida. Dr. McNelis, a capable and personable young psychiatrist, has taken over the clinical reins at Butner without even so much as a break in the pace set by his predecessor.

As clinical director of the big state hospital, Dr. McNelis directs the overall treatment procedures whose effectiveness is pushing Butner to the forefront among state hospitals of the nation. He conducts all staff conferences which determine diagnosis, map treatment plans, and decides when patients are well enough for discharge. Especially interested in the group psychotherapy method of treatment for mental patients, he supervises staff physicians presently conducting four such groups. At his desk he always finds plenty of time-consuming paperwork—dictation of case histories and progress notes, correspondence with patients' relatives, and other details. Add all these varied activities and you have just an inkling of the responsibilities involved in directing clinical treatment for more than 1,700 mental patients at the Butner hospital.

Guides Alcoholics' Treatment

But these duties seem to fall lightly on McNelis' shoulders, for at the same time he manages to keep a steady hand on the treatment wheels at the Alcoholic Rehabilitation Center. On almost any morning of the week you might see him hurrying out of his office in the main hospital building into his car and off to the nearby Center. Here he is apt to take time to chin with patients before launching into a lively group psychotherapy session conducted with an easygoing skill which encourages patients to enter freely into the discussion. Some of his afternoon hours are reserved for individual therapy with alcoholics, and more staff conferences back at the big hospital. One day a week he journeys

(Continued on page 30)

Program Pointers

By S. K. Proctor
EXECUTIVE DIRECTOR

WE wish to welcome two newly-appointed members of the Alcoholism Committee of the Hospitals Board of Control. They are: Mr. N. C. Green of Williamston, and Mrs. E. F. McCulloch of Elizabethtown. We look forward to a long and pleasant association with these two new members of our governing board.

Now that our five summer schools for teachers are over, we are attempting to evaluate their effectiveness in terms of attendance and other factors. For the fourth straight year, the course at East Carolina College was the best attended summer course on the campus, having a total of 76 students. Attendance at the other four schools was not as high as we had hoped, actually showing a drop over last year at Appalachian State and Fayetteville State. We don't understand the drop in attendance. Possibly it was due to a feeling on our part that the schools were well enough established so that we could slacken our efforts to promote attendance. We shall attempt to uncover other possible answers through discussions with faculty members and perhaps a survey of some of the former students.

Students who did attend the summer schools, expressed satisfaction and pleasure with the course material offered as well as the method of presentation. One East Carolina student's remarks are typical. She said, "This has been the most thought provoking instruction I have received in many years. If we, as teachers, can help to build more emotionally stable lives, we will not only help to decrease alcoholism but help the pupil in facing life in general."

Dr. Kelly, who conducted the majority of the lectures at East Carolina, received one of those pleasant and unexpected rewards which don't often come to those working in this field of alcoholism. At the conclusion of his lectures, the class presented him with a handsome desk pen set as a token of appreciation for what they termed his "excellent instruction."

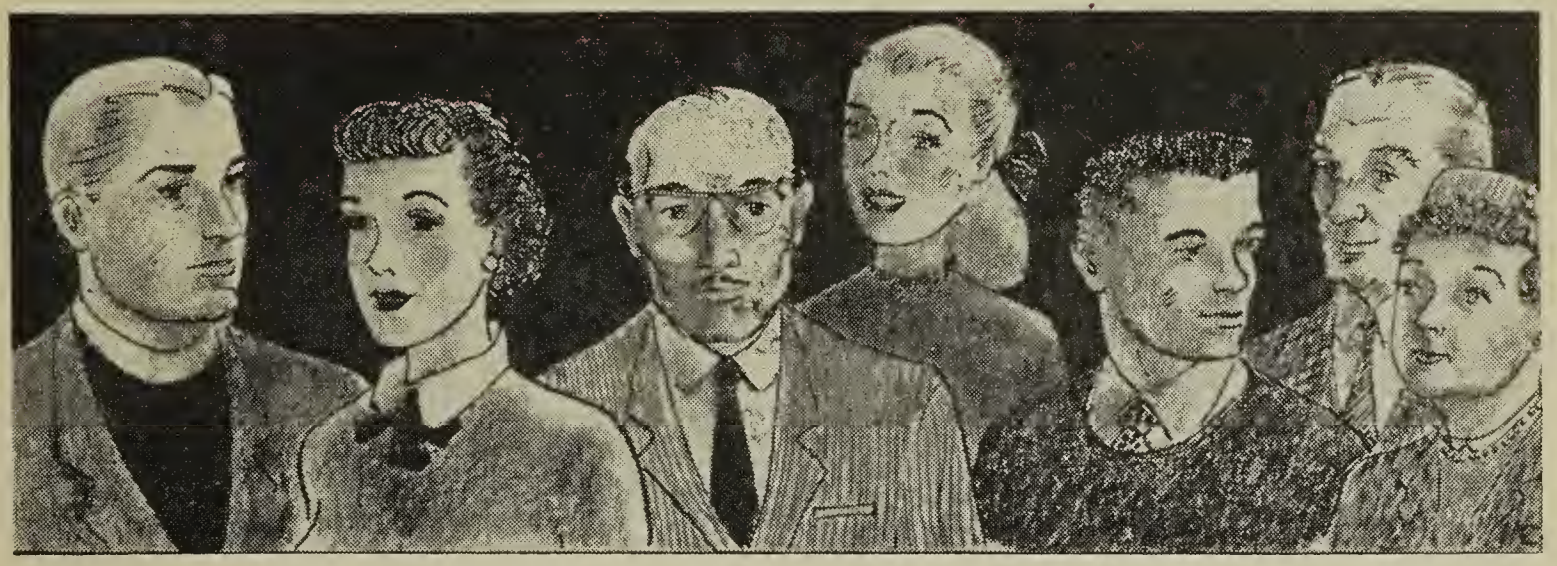
Scholarships To Yale

A breakdown of recipients of ARP scholarships to the 1956 Yale Summer School of Alcohol Studies shows the following professional classifications were represented: 2 physicians; 1 public health nurse; 6 social workers; 7 public school supervisors and administrators; 1 psychologist; 4 clergymen; and 1 public health educator. The entire faculty at Yale agreed that this year's class—which passed the 200 mark for the first time—was the best class in the 14-year history of the school. The group showed an upswing in professional status and in the degree of interest in the entire broad area of alcohol problems. Our own North Carolina

(Continued on page 31)

VOL. VI, No. 2 INVENTORY JULY-AUGUST, 1956

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM



What Makes People Happy?

Thousands of "happy" people concluded that happiness is a matter of attitudes — nine to be exact.

BY MYRTLE L.

COLORADO CITY, TEXAS

THE social work staff of a large university hospital interviewed thousands of people whom science would describe as "happy people"—self-integrated, well balanced, psychologically mature, emotionally stable people. They asked them: Why do you think you are happy, and what do you do that makes you happy? Then they analyzed the answers given.

When the staff had studied all the interviews and summarized all the suggested ways for keeping happy, they found that a total of nine points recurred in almost every interview. There were nine points which almost every one of the "happy" people felt contributed to their happiness. The research staff concluded that these must be the nine keys to happiness. Although not intended for alcoholics particularly, notice how closely the nine steps parallel the Twelve Steps of Alcoholics Anonymous. Here are the nine rules for happiness:

The first one: *Shun suspicion and resentment.*

Number Two: *Live in the present*

and in the future, 24 hours at a time. Most unhappiness stems from unwholesome preoccupation with the mistakes and failures of the past. They are important only as a passport to a better and wiser Today. Yesterday is gone; learn from it and forget it. Forgive yourself freely, for it is as vital to your happiness as forgiving others. Quit poisoning your day remembering resentments and suspicions of other people, even the alcoholic you may be married to. It is even more important to forgive yourself than to forgive the other fellow.

Their Step Number Three: *Don't waste time and energy fighting conditions you cannot change.* Have you ever heard that one before? There is little you or I can personally do about stopping a war, healing the incurable disease of a loved one, or changing the nature of those with whom we live. So stop hurling yourself again stone walls; accept the things you cannot change, and learn to live with them.

Fourth: *Cooperate with life instead of either trying to demolish it or run away from it.* You know, some of us are like those little boats in the bottles—we weren't going any place, we weren't coming from any place, until we found our way out and it seems that most of the things that make people most unhappy is their tendency to run away from life instead of rolling with the punches and trying to cooperate with it.

Number Five: *When you find yourself in the grip of emotional stress, force yourself to be outgoing to other people instead of retreating within yourself and building a prison of loneliness.* My, my! How familiar! When we're hurt, and when we can't be head of the committee, we sulk. We won't play. We'll go home and slide down our own cellar door. Now, we're all guilty of those immature things—alcoholic or non-alcoholic. We sit there, nursing our unhappiness. We have learned, as our Twelve Steps tell us, that when our unhappiness, this emotional stress, comes over us, to quit thinking of ourselves —to go out and help somebody else. There's *always* somebody worse off. If you're weeping because you have no shoes, remember the man who has no feet.

Number Six: *Refuse to pity yourself or seek self-justification in easy*

ACHILLES' HEEL OF THE ALCOHOLIC

LOW tolerance for tension is the character trait perhaps most often mentioned in connection with alcoholics. Stimulus and reaction are so closely interwoven, with the alcoholic, that they are practically one thing. Resentment, anger, hostility, rage, anxiety, frustration, mild apprehension, or sudden and overwhelming fury—anything that creates tension is the Achilles' heel of the alcoholic. The tension can come from some trivial occurrence of everyday life, or it can well up from some deep-seated psychic conflict, it makes no difference, the alcoholic personality is not gaited to withstand it. He is impatient. He is intolerant of his own moods and those of others. He demands that things go smoothly. If they do not, when they do not, he reacts immediately. His reaction is as swift as that of the baby who awakens hungry, experiencing tension. Like the baby, he is at once caught up in a squall.

—From "Alcoholism—Its Cause and Treatment"
By Ruth Fox, M.D., and Peter Lyon

North Carolina State Library
Raleigh

alibis that make you appear noble to yourself and to others.

Number Seven: *Cultivate the old-fashioned virtues of love, honor, loyalty, thrift, and church attendance.* This is science—cold analytical science—talking about love, honor, loyalty, thrift and church attendance. Now, we used to think that stuff was passe; that it was old hat and old-fashioned. How does a thing get old-fashioned? First, because it's been around a long time, and why is it around a long time? Because it works. And why does it work? Probably because it is part of God's sacred nature of things. I think a thing lasts long enough to get old because it has a spark of sacredness in the first place.

Set Realistic Standards

Number Eight: *Stop expecting too much of yourself.* When there is too wide a gap between the standard you set for yourself, and your actual achievement, unhappiness is inevitable. If you can't improve your standard, your performance, try lowering the demands upon yourself instead. If you can't be president, be vice-president—don't go home and sulk. There is not a top or a bottom—there is a perspective. And each of us has a job to do somewhere in between. If we set out each day to do the best we can, then it's a good day if we do it, whether we make .15 or $1,000. We've met the quota the best we could. But if we set our standard at $1,000 and make $999, we have failed because we didn't live up to the standard we had set. Let's just live the fullest and the best we can, and each day can then be a success.

Lose Yourself

Step Number Nine: *Find something bigger than yourself in which to believe.* Self-centered, materialistic, wordly people scored the lowest on the test for measuring happiness. Those who were altruistic, thought of the other person, had religious attitudes and spiritual feelings generally came out with a top happiness-rating.

Don't you think it's a little miraculous that these miserable, dejected drunks crawl first to their knees and then to their feet, and in the Twelve Steps find the same thing it took thousands of interviews by trained psychiatrists for science to find the Nine? Aren't they awfully similar? And aren't we the lucky ones? To me, it is a miracle.



CAUSE, EFFECT, AND TREATMENT

Excessive use of alcohol may create severe physical reactions, but, says this physician, alcoholism is primarily a personality illness which requires skillful and often long-term treatment.

BY GASTON DE LEMOS, M.D.

CHIEF-OF-SERVICE
STATE HOSPITAL, BUTNER, N. C.

THE main theme of this communication is the alcoholic as a personality, and how we attempt to treat alcoholism from a psychiatric viewpoint. However, I would like to make brief reference to the several clinical problems that excessive use of alcohol may create, and its physiological effects. These are:

1. Euphoria
2. Mental stimulation
3. Lowering of inhibitions
4. Decreased sense of fatigue, due to heightening of the sensory threshold.

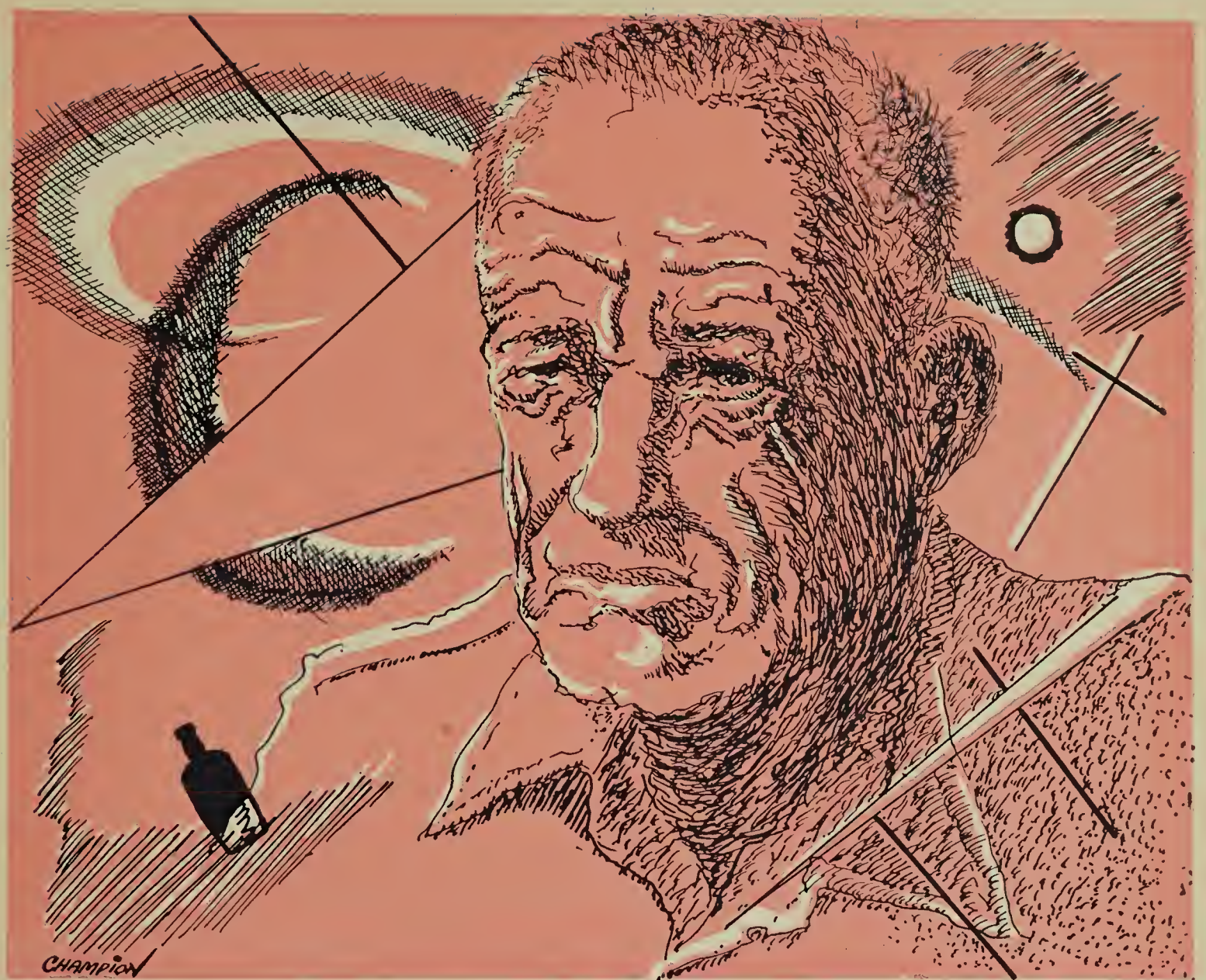
These subjective feelings make the intoxicated person believe that his efficiency and endurance have increased, which actually isn't so, because alcohol has a final depressing effect upon all physiological functions, associated with decreased oxygen intake by the brain tissues.

Usually, alcohol serves merely to release a reaction that is primarily psychogenic. In many cases, however, there is an interplay of metabolic and psychogenic factors, as we would see in any of the following better-known alcoholic psychoses:

1. Delirium Tremens
2. Acute hallucinosis
3. Pathological intoxication
4. Korsakoff's syndrome

Let's briefly review each one separately:

1. *Delirium Tremens*: Is an acute psychosis that may develop in the chronic alcoholic following unusual or prolonged drinking and drop in blood alcohol content; or it could be precipitated by accident or surgical intervention—lowering the bodily resistance to the toxic effects of alcohol. It is mainly characterized by: motor restlessness, sleeplessness, in-



jection of the conjunctivae, coarse tremor of hands, tongue and lips; elevated temperature; confusion; tactile spheres, (horrifying visions of bugs and snakes, or the feeling of insects under his skin.)

2. *Pathological Intoxication*: Occurs generally in mentally unstable individuals, to whom even relatively small amounts of alcohol may cause severe and striking mental symptoms, mainly characterized by: clouding of consciousness, hallucinations, increased psychomotor activity, with tendency to impulsive and destructive behavior. There may be deep anxiety or depression, leading to suicide. The disorder lasts ordinarily between one hour and one day, followed by prolonged sleep and total amnesia for the episode.

3. *Acute Hallucinosis*: Nowadays we tend to consider it as a psychogenic reaction created by alcoholic over-indulgence, rather than a true alcoholic psychosis. Its clinical features are determined by personality factors, often very close to schizophrenia. It is characterized by auditory hallucinations of an accusatory or threatening nature, with marked fear and apprehension, superimposed on a clear sensorium.

4. *Korsakoff's Syndrome:* It occurs only in chronic alcoholics of long standing, and its causes are mainly metabolic in nature, resulting from severe and prolonged Vitamin B deficiency. Clinically, it is characterized by amnesia, disorientation, confabulation (or memory falsification), euphoria; and symptoms of peripheral neuropathy.

Let's talk now about the psychogenic factors in alcoholism. It is universally accepted that alcohol be-

comes a problem to the habitual drinker only when it affords the satisfaction of a deep psychological need, such as tension created by anxiety, conflict, frustration, dependency or inferiority. In an individual with a well integrated personality there is an adequate tolerance for anxiety, frustrations, guilt, etc., not requiring the use of alcohol as a means to attain an end. In the maladjusted potential alcoholic either the tensions are extreme, or his tolerance is low, thus resulting in the excessive use of alcohol to the point of intoxication and the blotting out of reality factors, conducive to easier handling of his difficulties.

Vicious Circle

However, this in turn creates a "vicious circle," illustrated as follows: alcohol—lowering of inhibitions—anxiety created by the threat of uninhibited behavior—guilt over such behavior and over social unacceptance of drunken conduct—and again alcohol to relieve anxiety and guilt. As you can see, alcoholism in its true form is a "type" of gigantic proportions, and the undoing requires a great deal of motivation on the part of the patient, and skill and patience on the part of the therapist.

What kind of personality is that of the alcoholic? As we all know, one has to make room for many individual variations, which, perhaps, is what makes the problem difficult but interesting. However, I think that we can say that in almost every alcoholic there is a basic element of inferiority created by his recognized inability to properly handle and express his tremendous hostility, which, in turn, has its origin in frustration of the alcoholic's great dependency needs. In the history of an alcoholic's interpersonal relationships, there is always an overbearing, over protective parent (or parent substitute), who, through the process of the patient's psychosexual development, has made him a highly dependent individual. This alcoholic comes to recognize, at one time or another, this crippling aspect of his personality, and invariably makes one or more attempts at breaking his dependency; but he is usually awkward or unsuccessful. This creates in him a great deal of resentment and hostility towards the parent, which he cannot express for fear of being totally rejected and left alone to fight for his survival. And when an alcoholic gets married, it is usually to a mate with just about the same personality type of the dependency-creating parent, and to whom he transfers, now, all his resentment and hostility. Naturally, these feelings of hostility, resentment and inferiority create within him an excessive amount of anxiety. Now, alcohol not only relieves this anxiety but also allows him (because his inhibitions are lowered) the free expression of his inner rebellion. The pattern of psychological satisfaction is then set for a long time to come.

No Magic Formula

There is no magic formula for the treatment of alcoholism. As I have already pointed out, we must take into consideration the many individual variations among alcoholics. However, there are a few basic goals that we must set ourselves to reach, if we are to be fairly successful. Psychotherapy, either group or individual, is our most important tool. Through it we try to develop in the patient insight into his difficulties by bringing emotional conflicts to the conscious level, where they can be recognized and dealt with. This, of course, requires good motivation on the part of the patient. That is, his deep and sincere desire to recover from his illness, and his willingness

to cooperate with the therapist. When these two milestones are reached, then the therapist may begin to translate for the patient the true meaning of his emotional reactions, and later on, to advise the patient how to handle his own personality assets and liabilities. In this respect we should all be aware of the alcoholic's basic inferiority. It calls for an understanding attitude rather than a protective or condemnatory one. Pressure should never be exerted, because it will only create more tension and anxiety over his dependency. The alcoholic who has reached the "surrender stage" has his hand stretched out for help; it should be given in a fashion completely different from the manner of treatment which caused his illness.

Group Psychotherapy

At the N. C. Alcoholic Rehabilitation Treatment Center we make ample use of group psychotherapy associated with the showing of films emphasizing certain patterns of personality development often common among alcoholics. For example, we show films entitled "Feelings of Rejection," "Overdependency," "Feelings of Hostility," "Emotional Health," and "Emotional Needs of Childhood," as well as others concerning the effects of alcohol in the human body and other purely informative films. Our patients see one of these films every morning, and the group therapy session follows each showing. In a group situation our patients benefit from the free exchange of ideas pertaining to their common problem and from the support which they can give one another in the initial stages of treatment. There is less resistance in establishing a positive transferance to the therapist, as well as the re-establishment of a "sense of belonging." The patient has less reluctance in identifying himself with the main character of one or more films. The opportunity for "ventilation" of his resentment and hostility as well as his recognized inferiority and inadequacy is afforded in the group situation, and there are few patients who do not take full advantage of it. We also make use of "psychodrama," which, in a stage-like fashion, encourages the patient to enact meaningful situations or events in his life, with another patient acting as his counterpart. Often the roles are switched in order to allow both patients to "see" the problem from both angles. This, as you may imagine, is also of great value to a patient who has been sitting alone too many years in his isolated corner drinking away his self-pity.

Our main goal at ARC is not a complete cure of alcoholism in 28 short days. We try instead to create in our patients a small amount of insight and stimulate a reasonable degree of motivaton for his cure. This insight, when genuine, will carry him to a mental hygiene clinic in his community, where the long process of deep therapy shall begin. It is there, as well as in hospitals and in homes, that all of us are called upon to help the alcoholic regain his self-confidence and self-respect, and show him the way to the lost horizon of a well balanced, satisfying and happy existence.

BECAUSE the major problem is not alcohol, but personality, the patient must go through a long-range process of growth, once his immediate physical and personal problems have been taken care of. The goal of treatment is to help him accept himself as he is rather than continue to dream of what he'd like to be. He must make every effort to face and adjust to the personality problems he's been avoiding.

—Raymond G. McCarthy

When your husband is an alcoholic



What about the kids?

BY HENRIETTA S.
MEMBER
AL-ANON FAMILY GROUP

FOR sixteen years of our married life, I watched my husband deteriorate before my eyes as his alcoholic drinking became steadily worse. It was in this period that our children were born. Our son was fourteen and our daughter ten when Jack came into AA. So, in their most formative years, our household was an alcoholic one. But God in His wisdom was good to us. I would have gone into hysterics a few years ago if someone had told me that. In spite of, and not because of anything I did, our children were not too badly hurt by alcohol, for I now realize I did almost everything wrong.

I did what all of us have done at one time or another, and may still be doing. I tried to solve the alcoholic problem for my husband. In turn I begged and threatened. I pleaded. I asked my family and friends and even his boss to help him stop drinking. I asked God, in sort of a bargaining way, to do something about the drunken sot who was dirtying up our household. I promised God that if He would do something for me I'd do something for Him. I don't have to tell you that I was a wreck, mentally and physically.

Impact On Children

I don't believe any of us can watch another human being whom we love sink lower and lower, and not be hurt along with him. But in all the years I was fighting alcohol with the weapons of ignorance and self-pity, I was really not conscious of the impact of all this on the children.

It may be trite to say that the children are always the principal victims of a parent's alcoholism. But I feel that it is very true. An adult, particularly a wife or mother, has memories of the days when the alcoholic was not drinking to excess, happier times upon which one can look back, and which have formed a bond between husband and wife that is almost strong enough to survive any strain. Children rarely have these memories. From the moment they have any concept at all, they are faced with a drunken parent. The minute the child is old enough to play with other children and meet other children's parents, he knows something is wrong in his own home. So what happens?

Self-Pity Is Transferred

We, not knowing any better, transfer our own bitterness to the child. We make certain that the child will know what we think of our drunken husband. Oh, we may pretend for awhile and try to sell the child on the idea that Daddy is sick. We don't think he's sick and the child knows we don't, so the child knows that Daddy isn't really sick—just drunk. The child is permitted to witness sickening domestic arguments, bitter words and bitter, petty deeds. He is permitted to understand that he and his poor mother are the most unfortunate of human beings. They are stuck, so to speak, with a spineless, weak, no-good husband and father who neither loves them nor cares what happens to them.

The reactions of a wife and mother to the spectacle of a drunken husband are, I think, natural ones. You wouldn't expect her to nominate him as the Man of the Year.

But in the Al-Anon Family Groups we learn by the collective experience of all of us that this natural disgust, loathing and heartbreak are negative reactions. They are not constructive and they accomplish nothing. Of all the emotions that grip the wife of an alcoholic, I feel that self-pity is the most common. It takes practically no imagination for us to picture ourselves as martyrs, sacrificing our health for the sake of "keeping the

home together."

In my case I enlisted the aid of my children in this ceaseless war against their father. Naturally, they sympathized with me. Naturally, they defended me in every argument. Naturally, they joined with me in all manner of stratagems to foil my husband's insatiable thirst for whiskey. They helped me hunt the bottles he hid in the basement. It became a macabre Easter egg hunt to see who could find the bottle first.

Tug Of War

But at times, when the drinking was not so bad, their natural love for their father expressed itself. I remember now how I denounced them because they sided with him and not with me. This constant tug of war resulted in a pitiful sense of insecurity for them and made them noticeably nervous and unstable. In the end my will prevailed and they developed a feeling for their father far worse than good, clean hate. They developed a patronizing pity for him that was in reality no pity at all. They regarded him rather as a combination of clown and idiot. Who could blame them? Unwittingly, I encouraged them to feel that way. I can only say now that I did not know any better.

Spiritual Bankruptcy

Fortunately, our family was spared the financial disaster which is the lot of so many. There was always food in the house and the children were adequately clothed. What I am driving at here is that none of us suffered any real material loss, but spiritually, we were bankrupt. I was a good enough mother in a material sense. I saw that the children were clean, that the house was clean. I got them to the dentist, to school, and saw that they did their homework. I even saw that they went to Sunday School—but I never went myself.

What I did not know was that despite the fact my husband was half drunk all the time and very drunk some of the time, it would have been possible for us to find a measure of spiritual peace. The truth of the matter is, I was so engrossed in my husband's alcoholic problem that I had little time for anything else. The energies I could have devoted to my children were wasted trying to combat something against which I was powerless. Just as AA teaches the alcoholic, the Family Group has taught me that I, no less than my husband, am powerless over alcohol. It is within my power to do something about a great many problems that arise in our family life, but alcohol is not one of them.

Lessons Of The Past

It would be nice, in a way, to turn the clock back and start all over again, armed with the weapons the Family Group has given me. I would tell the children, and really mean it, that their father was a sick man; that he suffered from an illness that was no less real than if he were a diabetic or a cardiac sufferer. I would try to make them realize that he drank and got drunk because of a terrible compulsion inside of him that we could not understand nor do anything about. I would grit my teeth and avoid every argument dealing with alcohol or sparked by it. I would protect my children, of course, if our alcoholic became violent, but I would do it quietly, not dramatically, by removing them from the household if necessary.

That is a question which comes up often in our local Family Group. That is the way I answer it, and it is the way I think I would act if, Lord forbid, Jack should ever have a relapse. If the clock were turned back, I would build our lives together on

the assumption that the alcoholic breadwinning member of the family was an invalid who might at any time become so incapacitated that he could not work. It has happened in thousands of non-alcoholic families —blindness, polio, tuberculosis, heart attacks. Those things are hard to take, but they can be borne. They are not shattering and the family carries on.

But the clock cannot be turned back. Yesterday is gone forever and today is here. And today our family has AA and the Family Group. How can I tell you what it means to me and to us? It's just wonderful!

Let me tell you why I think we are happy. We are happy because we have God in our home. I don't mean that we have "gone religious" in the usual sense. It's really very simple. We have made God a member of our family. There are certain things only God can do. Jack supports our home. I keep the house. The children keep busy growing up. We don't expect God to do those things for us. But there are many things beyond our understanding that have to be done, and God does those for us.

So, when things don't work out the way they do in a television script, we have learned to accept them, confident in the knowledge that no matter how wrong they seem to us, they must really be right. This is the philosophy that we have tried to impart to our children toward facing the little things that can go wrong in school and with their friends.

Jack has learned this spiritual approach to living in AA. I have found it in working with my local Family Group and with my many friends at Headquarters. And the children, we hope, are just getting a little of it from both of us. I have taken my daughter to several Family Group meetings. When our son was home from school last week he expressed the desire to go to an AA meeting, his first, and did.

Happiness is not something you can buy by the pound like potatoes. I once thought it was. I once thought happiness could be created by arranging all the material things of life in a pleasing pattern. I once thought and have often said that if my husband would only stop drinking I would be happy. Instead, when he did, I felt frustrated and empty, like a dedicated nurse whose patient has

THE IRREVOCABLE PAST

I DO not let remorse over the happenings of the past cast a shadow over today. It is true that if I were able to relive certain experiences I might act differently, for certainly I should have the benefit of the understanding I have gained in the meantime. But to reproach myself now or to let a feeling of sadness remain in my heart can in no way contribute to the past, which is gone, nor can it help me to meet present experiences.

The word I did not say, the thing I did not do, the understanding I did not possess at some time in the past may cause me to have feelings of regret now, but the very fact that I feel regret now shows that I have grown in understanding, that I developed a greater capacity for thinking, speaking and acting wisely and lovingly. The feeling of regret or self-reproach vanishes when I bless the memories of the past as they come to mind and have the courage to let them go. As I face today with a free and happy heart I shall be able to meet present experiences so well that there will be no cause for future regret.

—Author Unknown

played her a dirty trick and recovered. Our children were delighted with their new father, but they began to get all mixed up again when their mother continued to be the same old mother, fretting, worrying, harping, criticizing—always looking back, never looking forward.

"Golly, Mom, what's the matter?" asked my big son. The matter was that I was still in a rut while my husband, happy and excited with the new life he found in AA, was leaving me behind as if I were tied to a post. The children could not accept him until I stopped wallowing in all the self-pity I had left over from the drinking days. Yesterday was gone, but I didn't want to forget it. I wanted to remember those days and nights, the drunken snores, the untouched dinner, the bloodshot eyes, the week-old beard, the hidden bottles, the sudden bursts of temper, and worst of all the harsh things that were said. What did he think I was, anyway—a Pollyanna? Pretend it all never had happened just because he had sobered up for a few months?

Then something happened that was to change my entire life. My son was dating a nice little high school girl whose father was a member of AA. So they had something in common—alcoholics for fathers. He told me that this girl's mother was a member of something called a Family Group.

I phoned the girl's mother—although I did not know her personally—and asked her about the Family Group. She took me to my first meeting almost three years ago, and I began to learn a new way to live. No miracle happened overnight, but there has been a very gradual lessening of tensions in our home. The children, both of whom were very high strung and of nervous temperaments, have calmed down and an atmosphere of security now dwells in our home. I am sure this is as much the result of my changed attitude as it is due to Jack's sobriety.

I feel that it is urgent for me to let everybody know what our Al-Anon Family Group has done for me. It has done the same for thousands of wives and mothers who needed help even more than I, and it *could* work for you and your children.

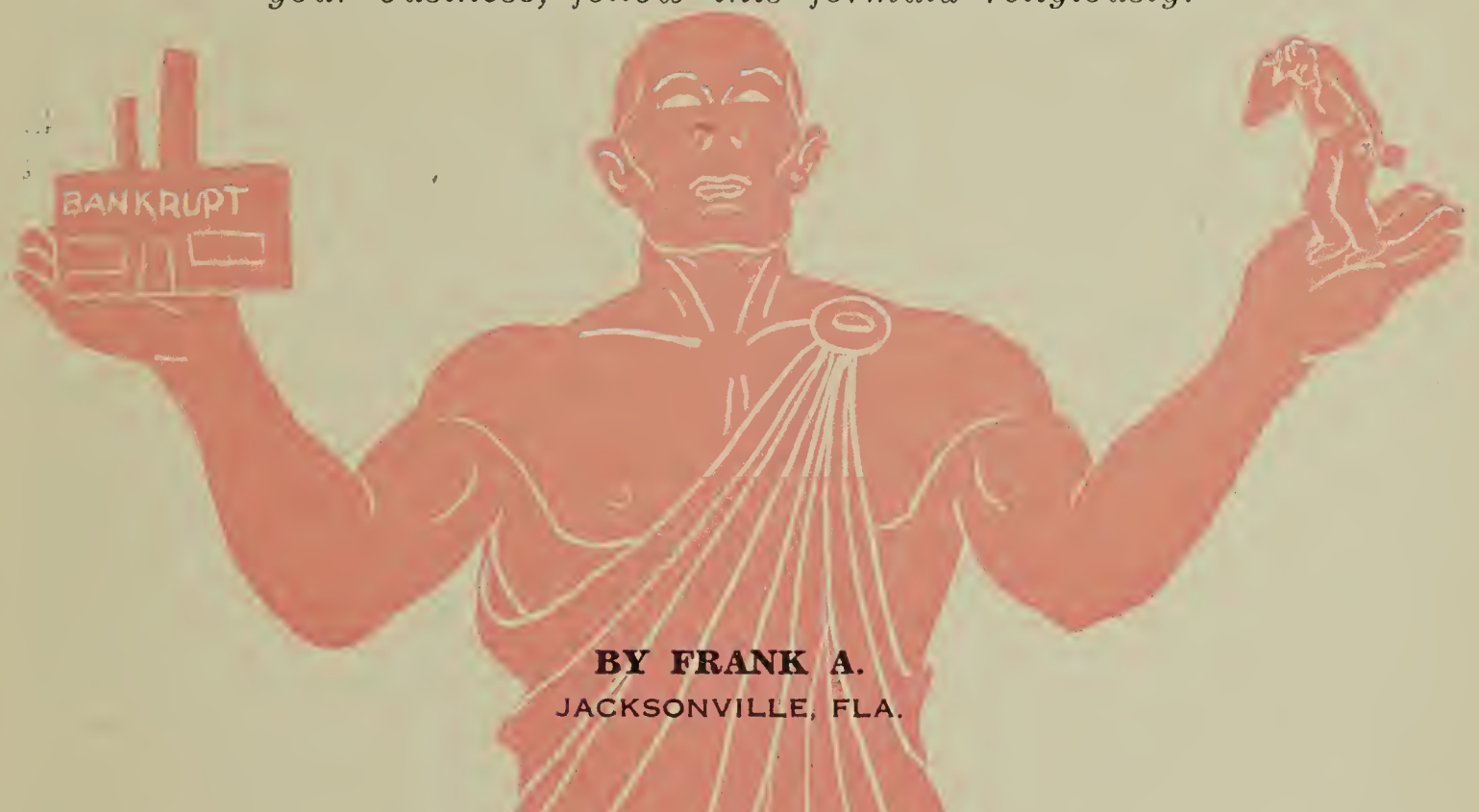
ABOUT HAPPINESS

A HAPPY life is a secure life and a life with a calm sense of adequacy. It is a life of sound mental health. These attitudes of happiness, and adequacy, and wholesomeness are readily built by happy and affectionate relationships in the home and by friendly give and take in social interaction with friends outside the home. Neglect and lack of love are almost certain to produce bad effects, but the presence of love is not in itself sufficient. It must be expressed by affectionate responses, by attention and kindly treatment, by genuine comradeship. The individual, child or adult, must feel that he belongs in an essential way in the life experiences of other people. The adult, even though confused and uncertain, can by frank self-analysis and intelligent planning and persistent practice always improve his relationships with people and consequently derive greater and greater inner satisfaction and security. It may call for a change of some of his personal habits. It may require new methods of social response. He may need to call upon a professional counselor for help. He may be assured, however, that earnest and persistent efforts, if accompanied by a humble and unselfish and kindly spirit, will bear fruit.

—from "Mental Health in the Home" by Laurence S. McLeod, Ph.D.

PARABLE OF THE 12 STEPS

If you would make a success of your life, or your business, follow this formula religiously.



BY FRANK A.
JACKSONVILLE, FLA.

ONCE, not too long ago as time is measured, there was a man over in the next town who had a business. I am not sure now what kind of business it was. It really doesn't matter; the point is that he ran it pretty much as the mood struck him. If he wanted to go fishing he simply locked up and went. Or if he didn't feel so good he'd stay home and rest.

As was to be expected, I suppose, the day came when there were bills to be paid that he could not pay and the bank note came due that he could not meet. He had realized, of course, for some time that his business wasn't making him a living and that his capital was running out. But he kept telling himself that others in his line of business were doing all right. "Something" would happen, he reasoned, that would straighten out his business affairs. After all, his friend and competitor over on the West side was making a go of *his* business, and anything Joe could do he could do better, or at least as well. Joe wasn't much for fishing and he seemed to have regular work habits, and everytime they met Joe didn't mind reminding him of it, in an offhand way, naturally. Like: "How's business?" "Been fishing lately?" or "How are the old tensions coming along?"

But Joe was right in a way. Joe could see that the business was going the bankrupt route, and out of friendship, was merely trying to help his old friend see it before it was too late.

So, this morning, with the stack of unpaid bills before him, the banker phoning him about the note, and the customers obviously taking their business elsewhere, he finally faced

up to the fact that his affairs were in such bad shape that it would take at least a Philadelphia lawyer to untwist them. "So," he thought to himself, "I might as well admit that I don't know what it's all about. Though it is a bitter pill to swallow, I guess I just don't know how to operate this business successfully.

STEP ONE

"We admitted we were powerless over alcohol—that our lives had become unmanageable."

In the clutter on his desk, he happened to notice a circular from a firm of consultants. It had come a few days before, but at that time he had tossed it aside, unread. "This is not for me," he had said.

Now, he picked it up and read it through. Gradually, it dawned on him that concerns such as this one in the circular were specialists in helping businesses to operate on a sound and profitable basis. Perhaps if he called them in, there might yet be hope. So he picked up his telephone and had the consultant firm send a man out that very day.

STEP TWO

"Came to believe that a power greater than ourselves could restore us to sanity."

That same day he signed a contract giving the consultants access to all his books and records and agreed to set his business up on the basis of their recommendations rather than to attempt to run it in his own fashion, since it was clear that he had made a rather poor job of it.

STEP THREE

"Made a decision to turn our will and our lives over to the care of God, as we understand him."

The first thing he was told to do was to furnish a full, accurate, and up-to-date inventory. It had been years since he had really attended to this, having always considered a rough estimate (shaded in his own favor) as being accurate enough for all practical purposes. This time, though, he did it honestly and carefully. In the process he uncovered some items that were worthless junk, merely occupying valuable space. But he also discovered some quite valuable goods he had completely forgotten. He went back over the ledgers, brought the entries up to date, and for the first time knew what his accounts payable and accounts receivable really were.

STEP FOUR

"Made a searching and fearless moral inventory of ourselves."

The man from the consultant's office looked over the books and discussed with him each item in the inventory and the accounts. This time he honestly admitted that some of his goods had no value, that he had not only been unpleasant but had even overcharged some of his customers. He also admitted that he had falsified his financial statement when he applied at the bank for a loan.

STEP FIVE

"Admitted to God, to ourselves, and to another human being the exact nature of our wrongs."

He agreed with the consultant that the best thing to do would be to clean out the useless goods in his storeroom, mark off all accounts which were definitely bad debts, and to be ethical and honest in his dealings.

STEP SIX

"Were entirely ready to have God remove all these defects of character."

In fact, to make certain it was done properly, he agreed to pay the consultants extra if they would attend to this themselves, allowing him to observe and learn the proper way of

doing these things. It was not necessary to pay them extra, however, because it was an honest, reliable firm, glad to assist in every way now that they were assured of his sincerity of purpose.

STEP SEVEN

"Humbly asked Him to remove our shortcomings."

While he was getting his affairs straightened out it was necessary to take steps to improve his volume of business. To this end he listed all former customers who no longer did business with him and made a note of the reasons they had taken their business elsewhere. He also listed the pitifully few customers and suppliers who, in spite of his abuses, had stuck by him. He determined to call upon each of them at the first opportunity and do whatever necessary to get back in their good graces.

STEP EIGHT

"Made a list of all persons we had harmed and became willing to make amends to them all."

The very next day he started his rounds. He swallowed his pride and apologized for whatever he had done, issued credit memorandums against former overcharges, and promised good service on all future orders. To his surprise, almost all shook hands and promised to give him another try. At one concern, however, where a few months before he had bribed the receiving clerk to accept an inferior shipment, the clerk had been promoted to a better job. The former clerk was embarrassed to see him and hastily explained that he had accepted the bribe because a prolonged illness in the family had left him desperately in debt and in need of money for medicines. He said also that his conscience had bothered him ever since. It would, of course, cost the former clerk his job if these facts were brought to the attention of his superiors, and since the goods involved had been totally destroyed in a fire shortly after delivery, no real harm had been done to anyone else. Therefore, it was decided that he would say nothing about the incident.

STEP NINE

"Made direct amends to such people wherever possible, except when to do so would injure them or others."

Upon the advice of the consultant and his friend Joe, to whom he had



"What am I doing here?"

told his problems and who had helped him in his reorganization, the man put in a perpetual inventory system. He now knew exactly where he stood every day. His accounts were posted daily, and an error in any transaction was immediately corrected.

STEP TEN

"Continued to take personal inventory, and when we were wrong promptly admitted it."

Slowly his business improved. Fishing was reserved for holidays and weekends. Every morning he was at his desk before the earliest employees arrived, using this time to plan the best ways to handle the problems of the day. The consultant firm assured him that part of their service was to advise with him at any time on his problems, so he did not hesitate to call them any time of day to ask an answer to some problem confronting him. This was hard for him to do at first, partly because he was afraid he would bother the consultant firm too much, partly because he wanted to show everyone that he could manage at least some of his problems alone. But a few costly mistakes soon convinced him that he needed the help of the consultant with all his problems.

STEP ELEVEN

"Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out."

Today, this poor, mixed-up man is a success. He still employs the same firm of consultants, and he calls them for advice at least once a day. He has followed their suggestions for such a long time now that he can almost guess in advance what they will think should be done. Although the proper handling of his business has become a second nature with him, he does not forget to keep closely in touch with his consultants lest he forget how he messed up things once and could do again.

He belongs to a trade association of people in his type of business, and at their last convention he was a participant in the panel discussion on "Successful Operation." Other people having trouble with their businesses now come to him for advice. He lets them know that all is not hopeless by describing the shape his business was once in and how he reorganized it into a successful operation. He enjoys talking with these unfortunate people and helping them to achieve success because it serves as a constant reminder to himself that he must never let his own business slip into the state it was once in.

STEP TWELVE

"Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."

HOW TO BE SUCCESSFUL

YOUR ambitions, if you're sensible, will be merely to improve yourself and better your position within realistic limits, while bringing as much happiness as possible to your family, and at the same time being of some use and help to others. With these ambitions—which can be realized by anybody—you can not only be a success but also know and feel that you are. It follows that you'll be free of that gnawing sense of failure which drives so many people to drink.

—Ralph A. Habas, Ph.D. in "How To Live Without Liquor"

PERIODIC ALKY ON VACATION



"Wait. Let's see if I've remembered everything. One case of vodka, spray gun, elephant gun, snake bite remedy, money left with clerk for hotel, ambulance and hospital bills. . ."

MICHIGAN'S PROGRAM ON ALCOHOLISM

This Program coordinates existing resources in an organized attack on the alcoholism problem.

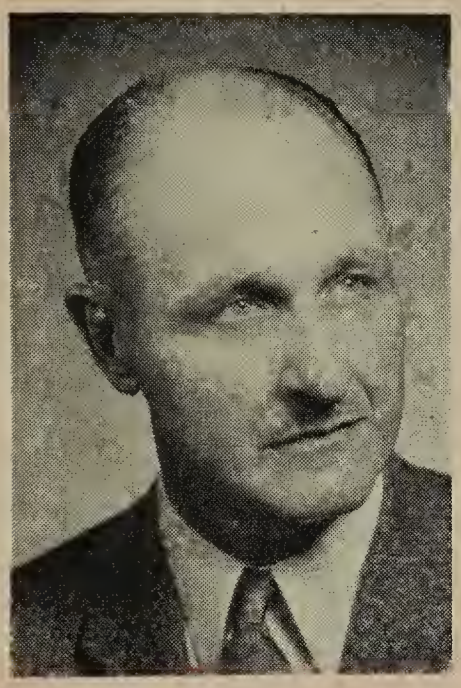
"COORDINATED EFFORT" might well be the key words to Michigan's Alcoholism Program. Board members are in agreement with the Legislature that established the Board in 1951, that alcoholism is a remediable human illness that cannot be isolated from other health problems. The ultimate goal of the Board's programs in treatment, research, and education is to make available to alcoholics the same services, with the same effectiveness as are now available to people suffering from other illnesses. This goal is based on a belief that alcoholism is not basically different from other human problems. The Michigan idea is that every physician should have as much knowledge about alcoholism as he does about tuberculosis or heart trouble; that every social worker should be as skillful with the alcoholic family as with the child showing behavior problems; that the clergymen should be as comfortable discussing alcoholism as he is discussing marital problems; that every general hospital should be as ready to offer services to the alcoholic as it is to the diabetic, and that the general public should be as aware of alcoholism as it now is aware of polio.

Achieving this goal will not end the age-old problem of the person addicted to alcohol, but it will reveal the problem so that the skills of the helping professions can be available to the alcoholic.

Improving Skills

The Michigan Board sees its role, not as one of treating alcoholics, but rather one of helping the qualified people now available to perfect their skills and improve their effectiveness in working with alcoholics.

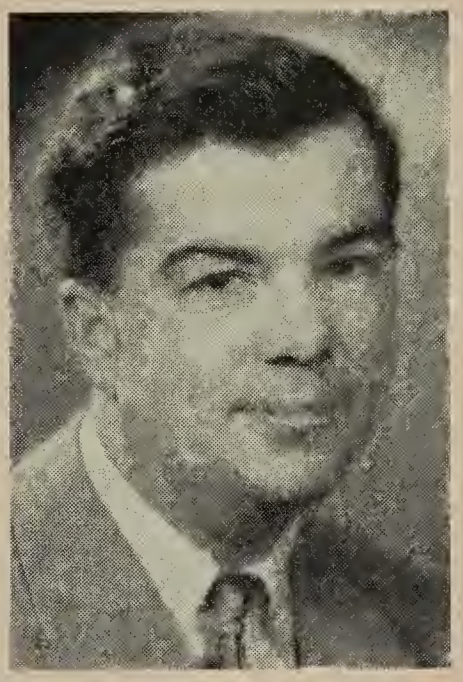
The present Michigan Board is made up of an attorney, a psychiatrist, a social worker, an educator and an industrial physician. One of these members is an arrested alcoholic and an active member of AA with several years of sobriety. The Board is an independent policy



HARLAN YELLAND
BD. CHAIRMAN



RALPH DANIEL
EXEC. DIRECTOR



GEORGE NIMMO
ED. DIRECTOR

making Board. Members are appointed for terms of three years by the Governor with the advice and consent of the Senate.

The Board is responsible to the Governor not only for making policy, but also overseeing the carrying out of these policies. Each Board member makes a unique contribution to the policy and program of the Board. They have proved themselves to be willing to devote time and effort for Board programs far beyond that which could be expected of a board that was just a policy-making board. Board members serve as special consultants to the director in specific areas such as education, research, legal aspects, budgeting and publications. They serve as resource people at alcoholism conferences. They are well informed on alcoholism and actively interested in the Michigan Board program.

The program is financed by an annual appropriation made by the Legislature. Money appropriated is taken from the liquor license fees and is limited to five percent of those fees. The Board hires a staff of four people to carry out its policies. The current appropriation is $136,000 for the fiscal year 1956-57.

Cooperative Program

Almost all of the Board's activities are cooperative programs with existing departments, agencies, organizations or institutions. This approach may lack many of the dramatic aspects of a public health program that operates as an entity. Many people who are reached by such a program are not aware that the Board exists. There may be less popular demand for an integrated program and it may not stimulate "grass roots" support, but in the long run the Michigan Board considers it the most practical approach to a major public health problem.

The state does not operate a treatment program directly. Local communities are encouraged to establish information and treatment programs and the state provides finan-

cial assistance in the operating cost. Program plans are set up by local agencies with the help of the Board Staff and submitted to the Board for approval with a request for funds. Once a plan is approved and a grant made, a contract for one year is drawn up. The locally operated program provides the State Board with progress reports on a quarterly basis.

No "Best" Therapy

It is the opinion of the Board that therapies for the alcoholic are still in the pioneering stage and that no therapy has yet been proved to be the "best" therapy. The Michigan plan allows for a flexibility and a variety of methods adapted to community needs and resources and the skills of the people employed. The Grand Rapids Rehabilitation Program utilizes an antabuse-education-and-Alcoholics Anonymous-combination. Jackson uses a personal counseling and tranquilizing drug combination. The Detroit program offers counselling therapy to homeless alcoholic men. The newly established program in Pontiac will offer counselling and referral services.

Administration

In Detroit a Mayor's Committee operates the center, independent of other city governmental agencies. The other three Michigan programs are administered by City Health Departments. The Board pays up to fifty percent of the cost of the four centers, but does not administer the programs.

The Board cooperates with independently financed treatment programs in Detroit and Flint through the sharing of educational programs.

The Michigan Board holds the belief that the general hospital has a role to play in the treatment of the acutely intoxicated alcoholic. A five-year study of this concept has been financed through a grant to a general hospital that now accepts alcoholics as they do other patients. The hospital staff tries to get the patients to see their illness as something more than intoxication and referrals are made to AA, to clergymen, or to social agencies.

Several other communities are planning rehabilitation and educational programs in cooperation with the State Board.

The Michigan Board has financed research projects in (1) evaluating the effectiveness of the treatment program used with homeless alcoholics in the Detroit rehabilitation program and (2) studying of juveniles picked up by the police on drunkenness complaints. Four research projects are being conducted at the present time. A continuing, basic research in the gastric effects of alcohol is in its third year. A study of the attitudes of law enforcement agencies as they relate to the alcoholic and a follow-up study of alcoholics committed to state mental hospitals are to be completed soon. A study of factors involved in teenage drinking is now in the rough draft stage. This study will provide the basis for planning better alcohol education for Michigan schools.

All of the research projects have been conducted by universities and state institutions on grants made by the State Board.

The Board's education program can be divided into three objectives:

1. Stimulating and training professional people who are, or should be working with alcoholics.
2. Informing the general public on alcoholism.
3. Assisting the State Department of Public Instruction in promoting effective alcohol education programs in the schools.

Programs with these goals are integrated with existing programs of

other agencies representing professional and lay groups.

Articles are written for such organizations as the Michigan Nursing Association, the Michigan Health Council, the Michigan Medical Society and the Michigan Congress of Parents and Teachers for publication in their periodicals. A mailing list of professional people has been made up with the cooperation of these and other similar groups. (This list is made up of people who have requested to be included in the list.) The Alcoholism Treatment Digest and other materials are sent regularly to more than five thousand people. Public libraries are supplied with literature, and films have been placed in film lending libraries. Radio and television programs are available.

Scholarship Program

Each year scholarships to schools of alcohol studies are awarded to professional people who are in a position to utilize this type of education. This year twenty-five people will attend the Yale Summer School of Alcohol Studies on Board scholarships and the same number will attend the Midwest Institute on Alcohol Studies. Yale students may become members of the Board's Speakers' Bureau and receive a small fee and expenses for talks given on alcoholism or alcohol education when such talks are not considered a part of the person's regular job.

The scholarship program and the Speakers' Bureau plan have made possible an educational program far more extensive than would have been possible with the Board's limited staff. The cooperation with existing agencies makes it possible to reach many people that could not otherwise be touched by an educational program.

Major Questions

All of the Board's efforts in the area of alcohol education in the schools have been in close relationship with the State Department of Public Instruction. A committee, jointly sponsored by the two agencies, and made up of local level educators, is working on two major questions, "What should schools teach about alcohol?" and "What are the best methods of alcohol education?" It is anticipated that this committee will develop teaching aids for Michigan educators based on the findings of the teen-age drinking study mentioned above.

The Michigan program is following a plan of working with existing agencies to meet the public health problem of alcoholism. While this approach may appear too slow to meet the hopes of some people, and while it may lack the fanfare that arouses public support and legislative recognition and backing, in the long run the Board is convinced that it is good government and a sound method of facing a public health problem.

CHILDREN of alcoholics seem more likely to become alcoholics themselves than youngsters from temperate families. There are several reasons. The children from families with a high record of mental disturbances will have a tendency to maladjustments themselves, including alcoholism. Children tend to imitate their parents.

—Alton L. Blakeslee, in "Alcoholism—A Sickness That Can Be Beaten"

SOBRIETY
STEP BY STEP

If you want contented sobriety, first try doing a housecleaning job on your own personality defects.

BY GEORGE G.
BUFFALO, N. Y.

The author, an alcoholic, has had eleven years of sobriety

I AM an alcoholic. I have an incurable disease. It is a sickness comparable to diabetes in that it can only be arrested or controlled. The disease of alcoholism is manifested by a physical allergy or sensitivity to alcohol plus an overpowering mental obsession which compels me to make the allergy operative by drinking. This peculiar physical reaction to alcohol in any form is the incurable part of my disease and will remain with me until my dying day. But the mental obsession to take the first drink can be controlled, thus rendering the allergy inoperative.

The popular conception of an alcoholic is the man on skid row. The man who through weakness of character, lack of self-control or some other reason best known to himself descended to degradation voluntarily. It has only in recent years become generally known that the great majority of alcoholics never see skid row. They progress sometimes hurriedly, but usually it is a gradual process from social drinking to problem or compulsive drinking. And, with the protective shelter of family and friends, they falter and stagger through life until an institution or grave claims them. This progression is one of the few things about the disease of which medicine is sure. Another is that once drinking has passed from the normal or social stage to the abnormal or compulsive stage, there is no return to social drinking. Therefore, for purposes of definition, anyone to whom drinking has become a problem is either already an alcoholic or is potentially one. Skid row is just the last step for some on the long journey of escape from reality through alcohol.

The most effective means yet found of combating this sickness are those suggested by Alcoholics Anonymous in their program designed to teach the problem drinker how to live contentedly without alcohol. Basically, the suggestions offered by AA are helpful to the man or woman who has a sincere desire to stop drinking because they halt this headlong flight

from life as it is. There are probably as many different ways of becoming an alcoholic as there are alcoholics. Instead of concentrating on the causes, AA suggests a complete housecleaning of personality faults of the type to be found in everyone but disastrous in their effect on the alcoholic. These include self-pity, intolerance and the chip-on-the-shoulder attitude toward life. Thus, through the process of self-change, the alcoholic becomes adjusted to life as he finds it, something which cannot be changed.

The program of Alcoholics Anonymous is based on twelve steps which contain the fundamental things which experience has taught are necessary for contented sobriety.

The first of these steps states that, "We admitted we were powerless over alcohol—that our lives had become unmanageable." The making of this admission is fundamental. It can be likened to the foundation of a house, necessary for all subsequent building. When an alcoholic becomes ready to admit this and ask for help, then he is truly ready to be taught how to help himself. It is interesting to note that this first step contains the thought that delays the entrance of many alcoholics into AA. Haven't you heard a relative or friend who is drinking too much say, "Well, maybe I am drinking a little too much, but I can take it or leave it alone. As soon as I get a couple of things straightened out, I'll be all right." They mean it, too. It seems to be an obsession typical of the alcoholic personality that to ask for help before he is completely beaten is a sign of weakness. Fortunately, arriving at the point of being completely defeated or hitting bottom differs with individuals. The first step of the AA Program is therefore deflationary. The alcoholic admits that he is powerless. He gets out of the driver's seat and asks for help.

Developing Humility

The second and third steps continue the development of intellectual humility. The second step, wherein the alcoholic comes to believe that only a power greater than himself can restore him to sanity, has a powerful effect emotionally. A characteristic common to all is emotional immaturity manifested in an inability to face reality. As he learns and grows in AA he realizes that help with all of the problems which were formerly unfaceable, is coming from a power greater than himself. He learns to depend on this source of help and finds it unfailing so long as he is humble enough to ask for it. He escaped to alcohol because he would not accept things which could not be changed. His escape now is through dependence on this outside help, turning over the problems to a dependable power. So it is natural that the alcoholic should make a decision to turn his will and his life over to the care of God as he understands him. This is the phrasing of the third step and the word, "God"

WARNING SIGNALS



EYEOPENERS

in AA is synonymous with higher power, and it conflicts in no way with religious concept. Each individual has his own understanding of what comprises the power greater than himself. Many newcomers find it difficult to make this decision. But through the insistence of AA that the mind be kept open to all new ideas it is usually reached within a reasonable length of time. Success in any new enterprise is ordinarily in direct proportion to the willingness to learn.

Personality Defects

Emotional instability is one of the deadliest characteristics of the problem drinker, so it is only natural that a concerted attack be made on the personality faults that are an outgrowth of this condition. Step four in the program of recovery suggests that we make a searching and fearless moral inventory of ourselves. The alcoholic asks himself, "Am I tolerant of the opinions and actions of other people? Am I resentful of their attitudes? Am I envious? Am I selfish? Am I quick to anger?" He asks these questions and many more of himself because the experience of others teaches him that these faults are part of his alcoholic thinking and, unless removed, place his sobriety in constant jeopardy. He is unable to regain self-respect until these flaws are recognized and an attempt made to correct them. His sobriety is dependent on the achievement of a measure of contentment. Dissatisfaction with his own character analysis is certainly not conducive to peace of mind.

In the fifth, sixth and seventh steps, he admits to God and to another human being the extent of his wrongs and then, after becoming ready to have his defects removed, he humbly asks help in removing them. This part of the Alcoholics Anonymous program compels the alcoholic to face truth and reality. And the self-deception which has probably been practiced for many years is finally recognized. Confession brings relief and a true perspective. Also, he must learn to forgive himself before he can forgive the world which he thought was against him. Perseverance and common sense in the application of these principles usually bring about an end to the alcoholic's long-held belief that he was self-sufficient and a well integrated person.

The eighth and ninth steps deal with the persons he has harmed and his making of amends. It is recommended that a list be made of all people deserving of reparation, material or otherwise. He gains in courage by confessing the wrong, but infinitely more so when the admission is made to the person against whom the wrong was committed. However, the rewards far exceed the embarrassment and inconvenience of making restitution, for he receives a great satisfaction having discharged a debt when he has a sincere determination never to repeat it. He matures emotionally and intellectual-

WARNING SIGNALS



BLACKOUT

ly when his payment of reparations is received with respect and admiration for his courage and fairness.

Like an established and successful business which takes inventory at regular intervals, AA recommends to the alcoholic in the tenth step that he continue to take moral inventory and when he is wrong, promptly admit it. This is insurance against his return to that pattern of thinking which made it so difficult for him to seek help in the first place. It is also a reminder that the process of implementing and securing a new and satisfactory adjustment to life is a painstaking and never-ending task.

Most alcoholics grow further and further away from all spiritual concepts. AA attempts to bring them back. The eleventh step suggests that they seek through prayer and meditation to improve their conscious contact with God as they understand Him, praying only for knowledge of His will and the power to carry that out.

Having found sobriety and a new way of living through the application of AA principles, the liberated alcoholic possesses the unique ability to teach and free others. He considers the exercise of this aptitude not only a privilege but an obligation. AA puts it this way in the twelfth and last step: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. Probably one of the greatest factors in the emotional stabilization of the problem drinker is his newly found desire to do everything in his power to help another human being. The necessity for setting a good example is in itself a steadying influence.

Apart from the steps and all their implications, the member is urged to remold his pattern of thinking to a program of 24 hours at a time. Heart and mind-rending remorse over the mistakes of the past and worry and speculation concerning the future are upsetting influences in the present. He is taught to look on the past as an unfortunate but valuable experience and to the future as a hopeful panorama made up of many things beyond his control. He achieves sobriety and its contributing happiness and serenity one day at a time.

PHYSICAL OR PSYCHOLOGICAL?

THERE is a disposition to seek to classify alcoholism as a disease which is in some way physiological. It is claimed to be the result of a dysfunction of metabolism, or of heredity, or of nutrition, or of the endocrine glands, or of this, that, or the other constitutional factors. Doctors as well as laymen strive to argue these conclusions; alcoholics pitiably share in the delusion. For delusion it is.

Alcoholism is a neurosis. Technically, it is classified as a psychoneurosis and subclassified as an impulse neurosis. It may appear in conjunction with an ailment of some other kind and thus offer a more complicated diagnostic problem. Such another ailment, while usually also mental, is sometimes physical. But alcoholism itself is a neurosis.

By Ruth Fox, M.D., and Peter Lyon in "Alcoholism: Its Scope, Cause and Treatment"

Personality Sketches

(Continued from page 3)

to Chapel Hill where he holds a clinical instructorship in psychiatry at the medical school. The teaching experience there gives him a satisfying change of pace from the hospital routine. He enjoys it and relishes the chance to pass on to medical students some of his experience in treating alcoholism and other emotional illnesses.

Even his off-duty hours are not entirely his own these days. He is often called on to give lectures and offer consultation to professional groups. Most of these extracurricular activities call for out-of-town travel—anywhere from the mountains to the coast. Just recently, McNelis was down in Wilmington where he helped conduct a workshop on alcoholism for social workers. He had similar meetings with nurses scheduled at Raleigh and Charlotte early in May. If his wife sometimes thinks she married a traveling salesman instead of a psychiatrist, she is partly right. Dr. McNelis considers "selling" the professional and lay public on modern psychiatric methods an important part of his job.

Good Qualifications

A good selling job by Dr. James Murdoch was responsible for McNelis' decision to leave his native Ireland and come to Butner. He had seen Dr. Murdoch's ad for psychiatrists in a British medical journal. Since he had "always wanted to come to America," he snapped it up, wrote Murdoch his qualifications. They were choice qualifications, too. He graduated in medicine at University College, Dublin, received the Diploma of Psychological Medicine after internship and psychiatric residency at Rain Hill Hospital in Liverpool, England. He followed this with three years as Psychiatric Specialist in the British Army. Murdoch wrote back an enthusiastic letter, describing in detail the workings of Butner Hospital and offered McNelis a job as staff physician. Impressed with the "progressive program" at Butner as Murdoch had described it, he immediately accepted the position, arriving at Butner in November, 1953.

Work With Alcoholics

McNelis and his family—wife Anna and two youngsters—settled easily into the community life of Butner. He was soon absorbed in clinical work at the hospital, meanwhile casting interested glances in the direction of the Alcoholic Rehabilitation Center. Dr. McNelis gained experience in group psychotherapy while serving his residency at Rain Hill Hospital in Liverpool. He frankly liked the method and was eager to try his hand with alcoholics. His chance wasn't long in coming, for Dr. Forizs, delighted to find someone already versed in Forizs' "pet" treatment, soon put McNelis in charge of several group sessions weekly at the Alcoholic Center.

Calling on his own clinical skills and on Dr. Forizs' kindly consultation, Dr. McNelis quickly gained competence in working with alcoholics. And like his predecessor, he is an enthusiastic evangelist of the group method. "Because the very intense inferiority feelings common to most alcoholics often interfere with successful individual therapy," he explains, "the support patients get from others in the group makes group therapy the choice treatment method for alcoholics." And if you ask the patients, they will tell you

that the friendly Irish psychiatrist is a competent person to administer it.

McNelis' busy professional life keeps him stepping. But, practicing his own advice to alcoholics, he saves some time for fun with his family and for an absorbing hobby in photography. And when he gets lonesome for a bit of Irish laughter, he has only to look up some of his many kinfolk living in seven or eight of the united states.

Some of the traditional luck of the Irish must have rubbed off onto the ARP and Butner Hospital in having Dr. McNelis ready and able to take over as Clinical Director. Let's hope that he will choose to remain in his important post for a long time to come.

Program Pointers

(Continued from page 4)

group reflected the same high quality noted in the overall student body.

Dr. Kelly and I were privileged to have been invited again this year to serve on the faculty of the Yale Summer School. Dr. Kelly conducted a very successful seminar on public education, and I served in a consultative capacity. In that capacity, I conferred with a number of students in attendance who are engaged in developing other state programs on alcoholism. It is my hope that out of our experience at the state level here in North Carolina, I was able to offer some guideposts and to stimulate some new thinking regarding the organization and administration of other fledgling state programs.

Besides my official duties at Yale, I always enjoy the associations there, for I feel that they are beneficial to me and to our own state program. It gives me the opportunity to discuss with the Yale staff our own activities, aims and dreams for the future and to get their valued opinions. I feel that it has been of service to the NCARP to have our efforts criticized and evaluated by these professional people who have long worked in the field of alcoholism. In addition, I had a chance while in New Haven to meet our North Carolina students, to tell them about the NCARP, why they were granted scholarships, and what part they can play in rehabilitation and prevention. This marked the seventh consecutive summer that I have been back to the Yale Summer School, and I believe that our readers can understand why I always look forward to the experience.

During the period June 30 through July 4 Miss Lytle, our Psychiatric Social Work Consultant, attended a workshop on psychodrama at the Moreno Institute in New York. The workshop was conducted by J. L. Moreno, a pioneer in the use of this treatment technique. Miss Lytle was accompanied by Miss Janet Haas, who has been Miss Lytle's assistant in conducting psychodrama sessions for alcoholics at the NCARP Treatment Center. Miss Lytle tells us that she and Miss Haas have already held a total of 23 sessions at the Center, and they are both enthusiastic over this treatment method. Their enthusiasm is apparently shared by the patients, numbering from sixteen to thirty at each session, who have participated. We hope to carry an article in a later issue of *Inventory,* giving a more complete picture of what psychodrama is and explaining its value to the patient.

During the next few weeks, we expect to work out details of the budget and complete all paper work prior to presentation to the Advisory Budget Commission and the Legislature.

What Every Child Needs For Good Mental Health

LOVE: Every child needs to feel that his parents love, want and enjoy him; that he matters very much to someone; that there are people who care what happens to him.

ACCEPTANCE: Every child needs to believe that his parents like him for himself, just the way he is; that they like him all the time, and not only when he acts according to their ideas of the way a child should act.

SECURITY: Every child needs to know that his parents will always be on hand, especially in times of crisis when he needs them most; that he belongs to a family or group; that there is a place where he fits in.

PROTECTION: Every child needs to feel that his parents will keep him safe from harm; that they will help him when he must face strange, unknown and frightening situations.

INDEPENDENCE: Every child needs to know that his parents want him to grow up and that they encourage him to try new things; that they have confidence in him and his ability to do things for himself and by himself.

FAITH: Every child needs to have a set of moral standards to live by; a belief in human values—kindness, courage, honesty, generosity and justice.

GUIDANCE: Every child needs to have friendly help in learning how to behave toward persons and things; grown-ups around him who show him by example how to get along with others.

CONTROL: Every child needs to know that there are limits to what he is permitted to do and that his parents will hold him to these limits; that though it is all right to feel jealous and angry, he will not be allowed to hurt himself or others when he has these feelings.

From A Pamphlet Distributed By
National Association For Mental Health

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
300 E. Northwood St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husband, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

MISS CARRIE L. BROUGHTON
STATE LIBRARY
RALEIGH, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

North Carolina State Library
Raleigh

SEPT.-OCT., 1956

B-2

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Can The New Drugs Help Alcoholics?

Program Pointers

Everyone Can Be Better Adjusted

The End Of A Bender

What The Alcoholic Must Learn

The Steps Go Both Ways

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

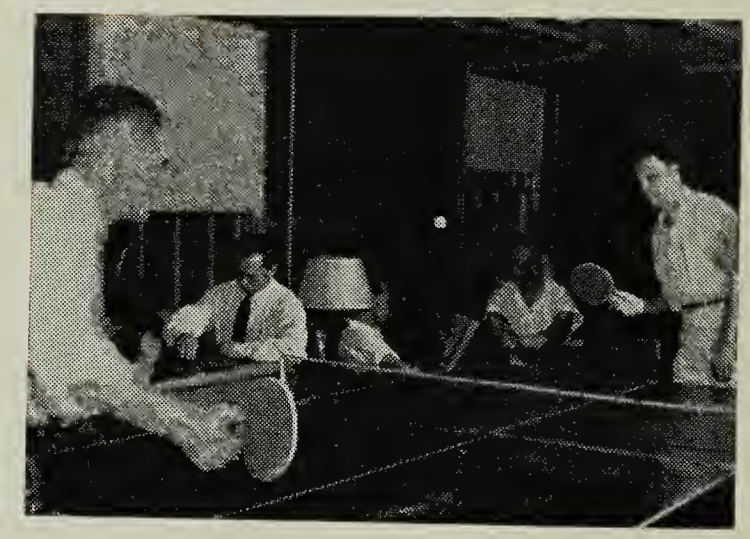
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

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SEPTEMBER-OCTOBER, 1956

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Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

LOOKING forward to another legislative session in January, we have recently completed laborious preparation of our budget requests for the 1957-58 biennium. After examining past and present activities and evaluating pressing needs, we are requesting a modest increase in appropriation that we may attempt to meet more adequately the public's demand for our services.

We felt that many of our readers would like to have an explanation of the philosophy and rationale under which we operate and which prompts us to request additional funds. Accordingly, we are reprinting here some of the narrative portions of our 1957-58 budget dealing with our general objectives, scope of activities, and the evidence in favor of our appropriation requests.

Statement of Legislative Authority, General Objectives and Scope of Activities

The Alcoholic Rehabilitation Program functions under the authority granted the N. C. Hospitals Board of Control by Chapter 122 of the General Statutes. It is charged with the responsibility of providing a program of treatment and prevention of alcoholism.

The in-patient treatment facility provides psychiatric, social, recreational, occupational, and pastoral counseling to white male and female patients who seek the 28-day treatment on a voluntary basis. The in-patient treatment center cannot be expected to provide complete recovery from alcoholism. Its purpose is to give insight into the reasons for each individual patient's compulsive drinking and to stimulate his motivation for continuing to improve his emotional and social stability as a guard against relapses. Patients are encouraged to continue this personality growth process through association with the Fellowship of Alcoholics Anonymous and by applying for out-patient treatment at the nearest out-patient clinic for alcoholics.

In this connection this Program provides financial aid to various mental hygiene clinics in the State so that they may be able to serve alcoholics and members of their families caught in the web of this personal and social illness.

The prevention aspects of the Program can roughly be divided into two main areas: prevention of emotional illness, which is at the root of compulsive drinking, and prevention of compulsive drinking itself. Education is the backbone of our activities toward these goals. By utilizing all possible communications media we educate the public to the concept that good child-rearing practices develop emotionally healthy adults and that

an emotionally healthy person is unlikely to develop alcoholism. The second aspect of our drive toward prevention deals with citizens who use alcoholic beverages but who have not lost control over their drinking. It is believed that knowledge of the 'pre-alcoholic' symptoms, if impressed upon the public, can motivate many excessive users of alcoholic beverages to undertake preventive measures while they still have the power of choice in the matter of drinking. Educational activity is directed toward all the citizens of the State through all possible means of communication and cooperation.

Justification of Budget Requests

The overtaxed facilities of the State Alcoholic Rehabilitation Program are a potent manifestation of increasing citizenry concern about the illness of alcoholism. The demands of our people for greater state action to combat this widespread public health problem strain the Program's resources.

Administration

Any health program directed at a particular disease has three essential components: treatment of those currently afflicted with the illness, education directed at the prevention of the disease, and continuing research into the causative factors and treatment procedures. To a marked extent improved treatment methods and greater insights for educational prevention are contingent upon new knowledge evolving from basic research. Alcoholism is a complex illness with many human and social elements involved. By no means do we have all the answers to the numerous psychological, sociological, spiritual, and cultural factors which are so intricately involved in the etiology of alcoholism. Only a continuing program of research carried on by adequately trained staff will give us the answers to many unsolved problems related to alcoholism. In this regard, our Program is at a standstill. We have no funds for conducting even minimal research. Because of lack of funds and personnel we cannot even evaluate the records maintained on our patients. These records, a fruitful source of new insights into the causes of alcoholism, the success of our treatment procedures, and many other primary problems, are accumulating by the thousands in our offices. To organize these records and reports into a rationalized system for effective research we need the assistance of trained personnel. Minimal requirements would include a full time director of research, a record librarian, a statistical clerk, and stenographic assistants. In order to carry this essential third aspect of our Program, a slight increase in our Administration Account is requested.

Out-Patient Program

The director of the Alcoholic Rehabilitation Program believes that the Program should not attempt to meet the complete needs of all alcoholics. To attempt to do this would provide an undue financial burden upon the State. Moreover, we believe the local communities must share in the responsibility of combatting alcoholism. A certain type of resource already exists in some communities that can be used to advantage as part of the total treatment program. This is the local Mental Hygiene Clinic. There is a number of these local clinics now in existence and still more are projected for the near future. We have instituted financial arrangements with those now functioning for which they offer valuable out-patient treatment service to alcoholics and their

(Continued on page 26)

Jail Tragedies

A FEW weeks ago the police picked up a man on a charge of public drunkenness, lodged him in jail, and found him dead the following morning. The autopsy showed no alcohol in his system. It did show the cause of death as a ruptured gastric ulcer.

The victim was a known alcoholic. He was apparently in a state of shock because of his acute illness, and arresting officers mistook his condition for simple intoxication.

Another tragic death occurred some time ago under slightly different circumstances, but the problem involved is basically the same. This person also was a known alcoholic and he was, according to several witnesses, definitely under the influence of alcohol at the time of his arrest.

But he was also sick, very sick, from another cause, and he begged loud and long for medical attention. For reasons which apparently satisfied investigating officers the victim did not receive medical attention. The next morning he rolled from his mattress to the floor and gasped his last few breaths. Heart attack.

Of course, no law enforcement officer would knowingly let a man die in his cell when medical attention could possibly save his life. Neither would an officer of the law jail a man for drunkenness if he did not actually believe the man was drunk. Ordinary common sense and human feelings dictate otherwise.

It is sometimes difficult for the medically untrained to distinguish between a state of shock due to serious illness or injury and acute intoxication, and it is doubly confusing when the shock victim has alcohol on his breath, however much or little he might have drunk.

This situation has caused other victims of epilepsy, diabetes, and various seizures to be taken to jail on drunkenness charges when they desperately needed immediate medical attention. Some have died in jail. Others had the real trouble diagnosed in time for the mistake to be corrected.

When the victim of shock or other serious physical condition is recognized as an alcoholic by the police and arrested for what appears to be intoxication it would seem that his chances for prompt medical aid are considerably slimmer than those of the

(Continued on page 28)

VOL. VI, No 3 INVENTORY SEPTEMBER-OCTOBER, 1956

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

EVERYONE CAN BE BETTER ADJUSTED

For everyone there is always the possibility of good adjustment if he really desires it.

WHEN we speak of alcoholism as a symptom of emotional illness, or, to put it another way, an inappropriate adjustment to life's problems, we are saying that the alcoholic does not react to life situations in the same manner as the so-called adequate, or adjusted individual.

What is adequacy? What are the attitudes, feelings and reactions of the stable person toward which the alcoholic or any other maladjusted personality must strive if he is to become a well-adjusted, adequate personality?

It is generally agreed that the differences between personality adjustment and maladjustment is principally one of degree. The difference is quantitative rather than qualitative. The normal individual, if subjected to enough stress and strain, can become emotionally ill and develop any of the symptoms accompanying emotional illness. The potentials for maladjustment are in every normal person and need only to be exploited through repeated or long-term stresses to break down stability and cause personality maladjustment.

In a like manner, the maladjusted person has the capacity for developing a normal, well-adjusted personality. As pointed out by Dr. Percival M. Symonds in his book, *The Dynamics of Human Adjustment,* "There is no limit to the extent to which a person can socialize his tendencies, learn to tolerate frustration, gain wider understanding of reality, learn to love more objectively. No matter at what stage he is in his adjustment, he can take steps toward achieving a more mature development, resolv-

ing infantile tendencies, and developing a more socialized and integrated adjustment."

Good adjustment is many things. Symonds describes it in terms of balance, wherein no one personality characteristic overbears the rest to produce an unbalanced, distorted, or twisted personality. He thinks of it also as maturity, which has no upper limit; that normality consists in working infantile wishes and anxieties through to a satisfactory conclusion. He describes adjustment as the degree of hardship and strain a person can undergo and adjust to successfully without disorganization. Normality, he says, is a compromise between our inner impulses, urges, and wishes and the demands of social living. The adjusted individual can desensitize his wishes so that they cause him less hurt if their fulfilment is denied. It is the maladjusted person whose desires are imperative.

What Are The Criteria?

What then are the criteria of good adjustment? There can be no universal goals, because no standard of normality can apply equally to all times and places, cultures and individuals. Each individual must work out for himself the satisfying adjustments possible for him in light of his inherited characteristics, his previous experiences, and the environment in which he must operate.

Symonds lists many criteria of good adjustment. The first is freedom from inner conflict. The normal person is in harmony with himself. The things he wants to do are the things he knows are right to do. Work is not a struggle; it is a thing he wants to do. He enjoys socializing; it expands his personality and promotes both the well-being of himself and others. He can direct his energies toward worthwhile goals because his energies are not being used fighting undesirable trends within himself.

The behavior of the well-adjusted person is rational. It makes sense. It reflects the use of his intelligence, which enables him to learn from his mistakes, to make compromises, to make substitutions where his wishes meet too much resistance. This criterion is known as effective intelligence.

Accept Reality

Another standard of good adjustment is the ability to accept reality. The well-adjusted person learns the necessity of giving up impossible wishes; he does not live in a world of excessive fantasy. He derives his main satisfactions from real life experiences. Within each of us are certain drives, fears and inadequacies which are evil or immoral. By recognizing and accepting the reality of our inner nature we gain insight and develop our ability to inhibit harmful drives, to work toward attainable goals, to find substitute satisfaction, thereby removing the necessity for covering up and trying to conceal the inadequacies within.

Self-Management

An important guidepost to adjustment is the ability of a person to accept full responsibility for himself and his behavior. If he can manage himself and make decisions with a minimum of worry, conflict, and advice-seeking he has a mark of maturity. He can postpone or deny himself pleasures of the moment when a worthwhile goal demands attention. He has self-control, restraint and independence. He can conform easily, but he has the originality and aggressiveness to propose better ways of doing things when he sees inadequacies in present practices or customs.

But the normal person does not lead an ascetic life. He has a certain

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Raleigh

freedom of emotional expression. He can laugh and smile easily and freely. He can play, and he can express himself through creative living. He enjoys sports, games, hobbies. He has the ability to love. He can enjoy erotic pleasure without feeling it is bad or sinful, but sex expression is not the dominating characteristic of his personality.

The well-adjusted person can also show anger, hostility or aggression when necessary. He does not sit idly by while others attempt to take advantage of his good nature. He knows when it is wise to fight back as well as when to smother the angry word, the aggressive push.

He can love others for themselves rather than for the good others can do for him. He enjoys social contacts and doing things for and with the group to which he belongs. His personality grows to greater maturity through his desire to develop tolerance and understanding, through his ability to let the other fellow be happy in his own way. He gets along well with other people. He avoids distrust, jealousy, and quarrels.

People Like Him

Other people like the well-adjusted person. He is accepted by them. He is often chosen to head committees, to spark a community or club undertaking. He respects the dignity of every individual and does not block any person's freedom to speak and act for himself.

The adequate person can enjoy the company of members of the opposite sex whether in conversation, at work, or in any social occasion. He does not feel ill at ease around them.

A sign of good adjustment is the depth of loyalty one has for his friends and the degree of persistence he has in discharging his duties. He is no fly-by-night operator. He finishes whatever he starts to the best of his ability, unless new circumstances or better judgment directs otherwise, because the well-adjusted person is not inflexible in the face of insurmountable obstacles. He does not butt his head against a stone wall any longer than necessary.

He eats and sleeps well. He cultivates good physical health but he is not preoccupied with the state of his health and he most certainly does not harp on his ailments and complaints as does the hypochondriac.

The world is a friendly one to the adjusted person. He realizes there are people who may desire to hurt

THE WELL ADJUSTED PERSON

Is free from inner conflict.

Acts sensibly. His behavior can be explained.

Accepts reality.

Accepts responsibility for himself and his behavior.

Enjoys work, play, hobbies, love.

Can show anger, aggression, when necessary.

Can love others for themselves rather than for the good they can do him.

Is accepted, genuinely liked, by others.

Enjoys company of the opposite sex.

Has deep loyalty to friends.

Is persistent in discharging duties.

Cultivates good physical health.

Looks for and expects the best in people.

Evaluates his talents, goals, abilities frequently.

Recognizes and accepts self-destructive tendencies in himself.

Accepts generosity, love, from others willingly.

him in some way, but he prefers to look for and expect the best in people. His world is not filled with dangers.

Everything human changes. The normal person knows this, and his growth toward maturity is marked by frequent evaluations of his talents, goals, and abilities. He strives to keep his wishes within realistic limits and at the same time endeavors to make full use of his ability to attain the highest goals within his capabilities.

Self-Punishment

The person with an over-strict conscience usually has strong tendencies to inflict punishment upon himself as a defense against guilt feelings. He may sacrifice himself as a martyr, or deny himself the opportunities for self-betterment, or willingly allow other people to take advantage of him. The well-adjusted person on the other hand tries to recognize self-destructive tendencies within himself, admitting to himself that he has such tendencies. Recognition of them helps to reduce over-activity of conscience. Admission of the presence of these tendencies encourages him to re-direct his impluses into socially acceptable outlets.

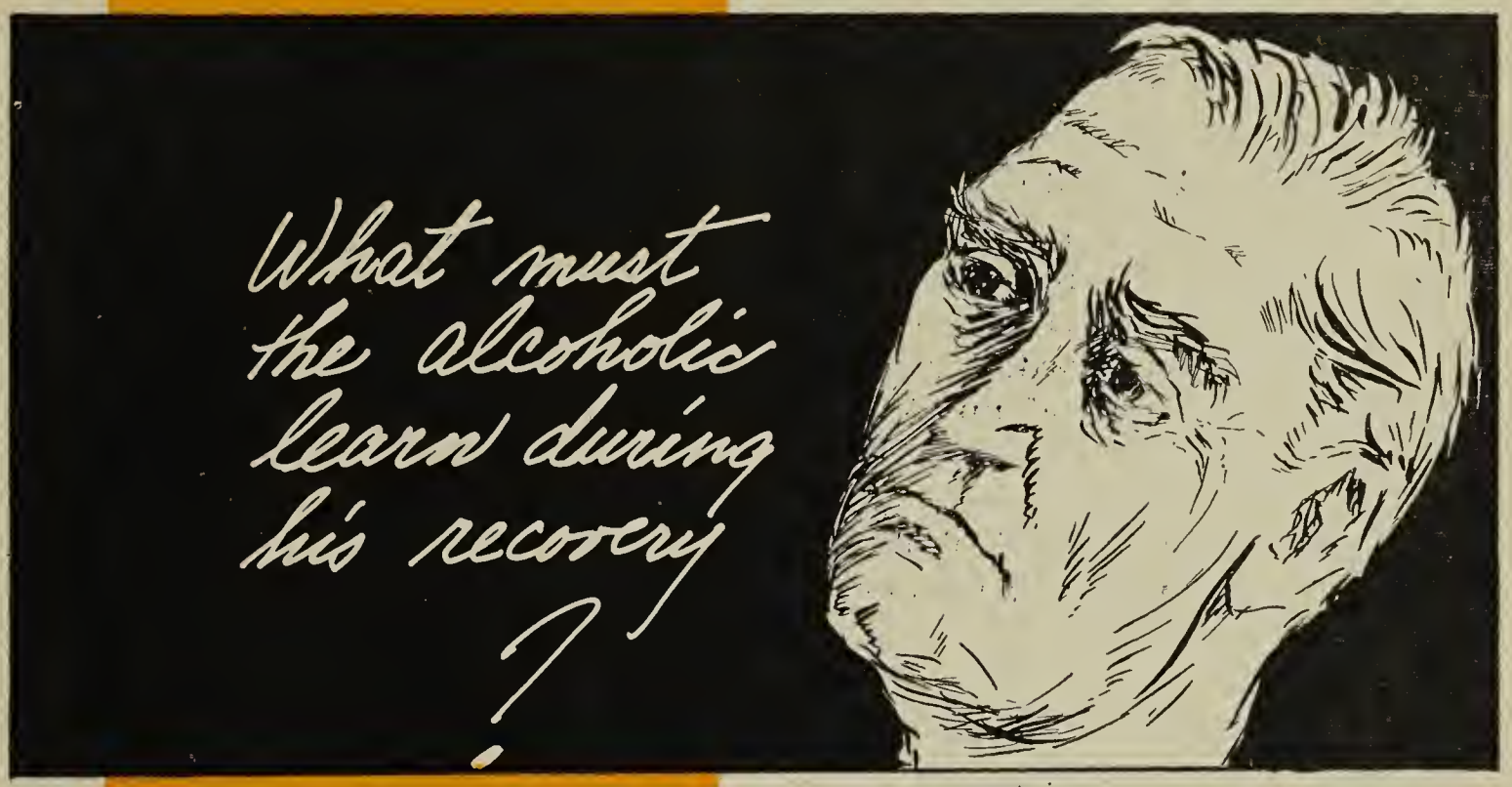
All of us are to a certain degree dependent on other people for many of our needs. Basic among these needs is the ability to accept love from others. The neurotic, particularly the alcoholic, usually differs markedly from the well-adjusted person in his ability to accept love. The neurotic, who most wants to be loved by others, often rebuffs love that is offered to him. The well-adjusted person is able to accept love and devotion without considering his dependence on others a threat to his self-sufficiency.

Symptoms of maladjustment such as alcoholism, drug addiction, chronic nagging and complaining—to mention a few—are serious in that they drain off large amounts of energy which should be put to more personally satisfying and socially acceptable—and therefore more creative—uses. The goal of every individual, according to Dr. Symonds, should be the achievement of a good working relationship with the world in which he lives. "One would do well," he says, "to judge the quality of adjustment in terms of ability to work, play, and love, to feel happy and contented, to accept reality, to express ones emotions freely, to exhibit normal inhibitions, rather than to pattern one's behavior according to any set formula or standards."

No one can expect to find happiness by wishing for it or demanding it or by deciding that he is going to be happy. By changing his way of living, by modifying attitudes and tensions, he can be helped to a more satisfactory adjustment. In the case of the neurotic individual, this means that he must accept the help of other persons who can introduce him to the ways of better adjustment. Our families, our friends, our church, social and business connections—all can help to release the power of our energies for satisfactory living. For everyone there is always the possibility of happiness and normality if he really seeks these things.—HMC

A STRONG and well-constituted man digests his experiences (deeds and misdeeds all included) just as he digests his meats, even when he has some tough morsels to swallow.

—Friedrich Nietzsche



HE MUST..

The following item is reprinted from the July, 1953, INVENTORY by popular request. It originally appeared in a brochure published by The National Committee on Alcohol Hygiene, Inc.

BY THE LATE ROBERT V. SELIGER, M.D.

BE CONVINCED from his own experience that his reaction to alcohol is so abnormal that any indulgence for him constitutes a totally undesirable and impossible way of life.

BE COMPLETELY SINCERE in his desire to stop drinking once and for all.

RECOGNIZE that the problem of drinking, for him, is not merely a problem of dissipation, but of a dangerous psychopathological reaction to a (for him) pernicious drug.

CLEARLY UNDERSTAND that, once a man has passed from normal to abnormal drinking, he can *never* learn to control drinking again.

COME TO UNDERSTAND that he has been trying to substitute alcoholic fantasy for real achievement in life, and that his effort has been hopeless and absurd.

RECOGNIZE that giving up alcohol is his own personal problem, which primarily concerns himself alone.

BE CONVINCED that at all times, and under all conditions, alcohol produces for him not happiness, but unhappiness.

COME TO UNDERSTAND that the motive behind his drinking has been some form of self-expression, some desire to gratify an immature craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.

UNDERSTAND that alcoholic ancestry is an excuse, not a reason, for abnormal drinking.

REALIZE that any reasonably intelligent and sincere person who is willing to make a sustained effort for a sufficient period of time is capable of learning to live without alcohol.

AVOID the small glass of wine—i.e., the *apparently* harmless lapse—with even more determination than the obvious slug of gin.

NEVER TO BE SO FOOLISH as to try to persuade himself that he can drink beer.

NEVER TO BE SO CHILDISH as to offer temporary boredom as an excuse to himself for taking a drink.

DISABUSE HIS MIND of any illusions about alcohol sharpening and polishing his wit and intellect.

LEARN to be tolerant of other people's mistakes, poor judgment, and bad manners without becoming emotionally disturbed.

LEARN to disregard the dumb advice — and even dumber questions — of relatives and friends without becoming disturbed emotionally.

RECOGNIZE alcoholic daydreaming—about past "good times," favorite bars, etc.,—as a dangerous pastime to be inhibited by thinking about his reasons for *not* drinking.

LEARN TO WITHSTAND success as well as failure, since pleasant emotions, as well as unpleasant ones, can serve as "good" excuses for taking a drink.

LEARN to be especially on guard during periods of changes in his life that involve some emotion or nervous fatigue.

TRY TO ACQUIRE a mature sense of values and learn to be controlled by his judgment instead of by his emotions.

REALIZE that in giving up drinking he should not regard himself as a hero, or martyr, entitled to make unreasonable demands that his family give in to his every whim and wish.

BEWARE of unconsciously projecting himself into the role of some character in a movie, book, or play who handles liquor "like a gentle-

man," and of persuading himself that he can—and will—do likewise with equal impunity.

LEARN the importance of eating —since the best preventive for that tired, nervous feeling which leads to taking a drink is food—and must carry chocolate bars or other candy with him, at all time, to eat between meals and whenever he gets restless, jittery, or tired.

LEARN HOW to relax naturally, both mentally and physically, without the use of the narcotic action of alcohol.

LEARN TO avoid needless hurry and resultant fatigue by concentrating on what he is doing rather than on what he is going to do next.

NOT NEGLECT care of his physical health, which is an important part of his rehabilitation.

CAREFULLY FOLLOW a daily self-imposed schedule which, conscientiously carried out, aids in organizing a disciplined personality, developing new habits for old and bringing out a new rhythm of living.

NEVER RELAX his determination or become careless, lazy, indifferent, or cocky in his efforts to eliminate his desire for alcohol.

NOT BE DISCOURAGED by a feeling of discontent during the early stages of sobriety, but must turn this feeling into incentive to action which will legitimately satisfy his desire for self-expression.

NOT DROP HIS GUARD at any time—but especially not during the early period of his reorganization, when premature feelings of victory and elation often occur.

UNDERSTAND that, besides abstinence, his real goal is a contented and efficient life.

APPRECIATE the seriousness of his re-education and regard it as the most important thing in his life.

REALIZE that most people seeking psychological help for abnormal drinking are above average in intellectual endowment, and that, while drinking means failure, abstinence is likely to mean success.

NEVER FEEL that any of these commandments are in any way inconsequential, or secondary to business, play, or whatnot; and he must conscientiously observe every one of them, day in and day out.

WILL THE NEW DRUGS HELP ALCOHOLICS?

Here's the story on four new drug discoveries being tried on alcoholics. Some are proving helpful, but, say researchers, they are not "cures."

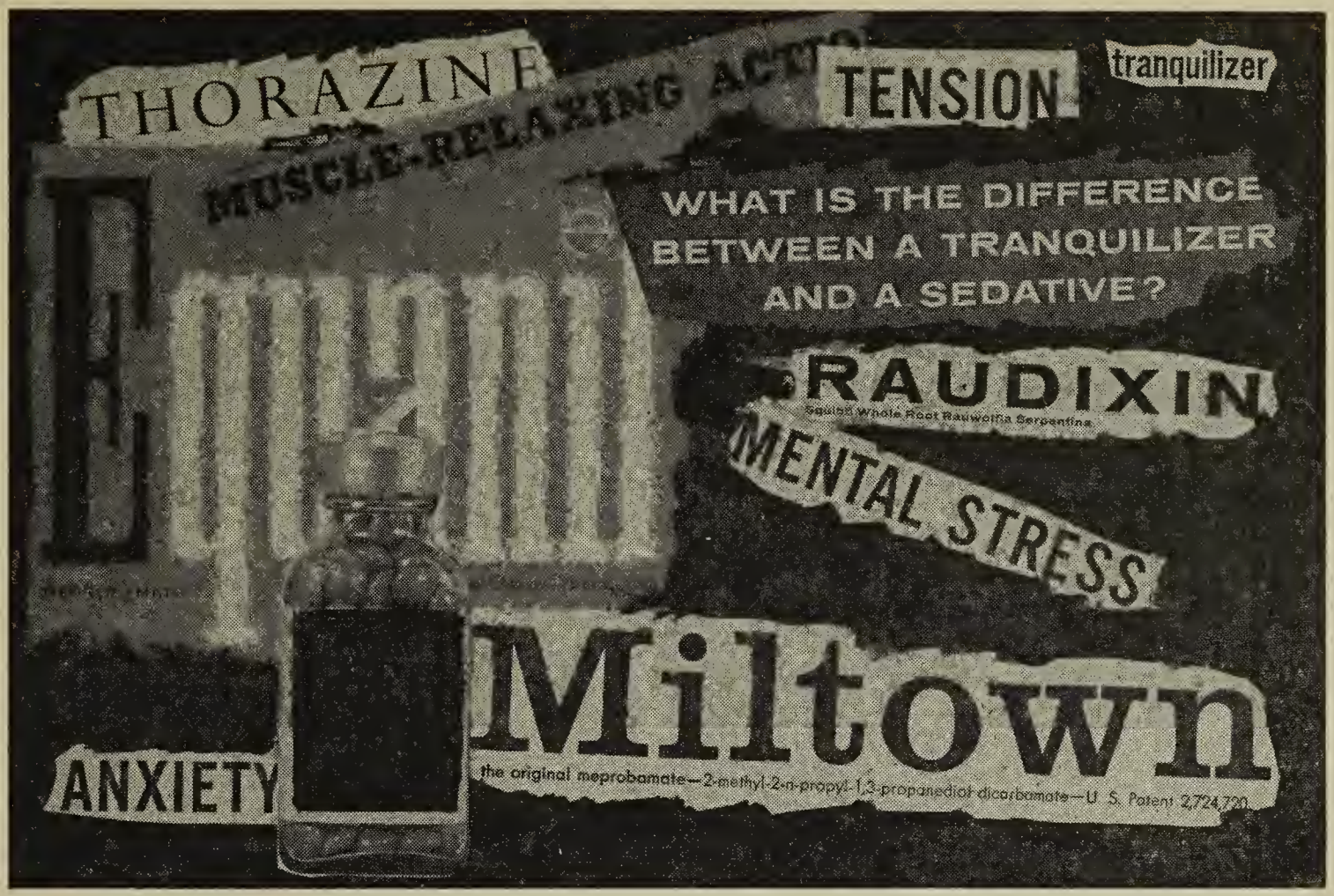
FOR years science has been on the hunt for better, more effective drugs with which to treat alcoholics. The search is bearing fruit. In the past two decades many new drugs have been developed and tried in alcoholism therapy. Some have given encouraging results, but we aren't on the threshold of a golden age in which happiness and contentment can be dispensed from drug counters or alcoholism cured with a special pill.

Nevertheless, clinical tests of certain new drug therapies do show them to be promising tools in the total treatment of alcoholism.

Two "families" of drugs are proving effective with selected alcoholic patients. One group, called *tranquilizers,* calms anxieties and tensions and produces feelings of relaxation and ease. The other group, known as nervous system *stimulants* or "mood lifters," perk up the spirits of patients suffering from feelings of depression and apathy. Unlike the barbiturates, these drugs produce their effects without apparent danger of addiction.

Some of the tranquilizers are particularly effective in giving quick and dramatic relief from the distressing symptoms of the acute or withdrawal stage of alcoholism. Their use as an adjunct to psychotherapy is still in the experimental stage, but early reports look hopeful. For example, for some patients formerly using alcohol for relief from tension and anxiety, certain of the tranquilizing drugs can be substituted to offset a possible drinking bout and enable the patient to sustain his sobriety. In a similar way, certain of the "mood lifters" can sometimes forestall alcoholic bouts when they are precipitated primarily by feelings of depression and unworthiness.

Clinicians are cautious about enthusiastic claims for any of the drugs. One prominent North Carolina psychiatrist, Dr. Richard C. Proctor of



Winston-Salem, has been conducting clinical studies on several of the new drugs in treating alcoholics. Here is what Dr. Proctor says about them: "None of these drugs is a cure in itself. But with close supervision and concurrent psychiatric therapy, one is often able to break up the drinking cycle and at the same time form a relationship with the patient, which is so vitally important in therapy of alcoholism."

Two points in Dr. Proctor's statement bear emphasis. First, he makes no claim, nor do other clinicians, that any of these drugs is a cure in itself. No one drug has been beneficial with every alcoholic treated. It is not expected that one ever will be. The underlying causes of alcoholism differ from one patient to another. Therapy must be varied, too, to take into account these differences.

Second, don't discount the important role of psychotherapy or that of the physician himself when an alcoholic shows improvement under drug therapy. It is likely that an alcoholic is benefited by drugs in direct proportion to the amount of kindness and genuine interest shown him by his physician. Take away these personal factors plus the benefit of self-understanding through psychotherapy, and any medication is likely to prove ineffective.

With these words of caution against over-optimism there follows an explanation of four representative new drugs being used in treatment for alcoholism. Three are members of the tranquilizer family and one is a nervous system stimulant. The choice of drugs for consideration in no way constitutes an endorsement of them by the NCARP, but was dictated by the available amount of clinical evidence as to their effectiveness. Here they are:

CHLORPROMAZINE

How to manage the acutely ill alcoholic when he first appears at the

hospital after a bender is still a subject of study and experiment. One of the new drugs being used for this purpose is chlorpromazine. Some trade names are: Largactil, Thorazine, Phenergan, 4560-R.P., Compound 2601-A.

Chlorpromazine has proven most effective in the treatment of the acute or withdrawal stage of alcoholism.

What will the drug do for the acutely ill alcoholic who is "shaking one out" and may be near DT's? Ordinarily, after starting chlorpromazine therapy, the patient will fall into a restful sleep which may last from 3 to 12 hours. The drug does not act like a narcotic, however, for the patient can be easily aroused to take fiuids and will quickly fall asleep again.

Calms Upset Stomach

Another striking action of chlorpromazine is its settling effect on the digestive system. Even patients who have been vomiting almost continuously are soon able to retain light foods and liquids. They can usually return to a normal diet within 24 hous.

Finally, chlorpromazine has a direct calming effect on the "shakes"—tremors, overactivity and restlessness—which appear when alcohol is withdrawn from a patient just off a bender.

The claims for chlorpromazine in the treatment of acute alcoholism are backed by an increasing body of clinical evidence. One researcher, E. H. Mitchell, used chlorpromazine on one half of a group of 306 patients admitted to a sanitorium for acute alcoholism. Some were already in DT's. On the other half of the group, he used conventional therapy consisting of barbiturates. The group receiving chlorpromazine showed a marked difference over the barbiturate group. They soon became quiet and dropped off to sleep but could be easily aroused. When awake they seemed aware of what was going on around them but appeared to be too relaxed to react to their surroundings. Nausea and vomiting disappeared within a short time.

The group receiving barbiturates obtained less relief. It took them between 18 and 24 hours longer to retain food than those who received chlorpromazine. The barbiturate patients had to be kept in the hospital an average of 24 hours longer.

Mitchell examined his evidence: eighty-five per cent effective sedation with chlorpromazine; simplified nursing care; shortened hospital stay. He concluded that chlorpromazine is a useful adjunct in the treatment of acute alcoholism. Other researchers in the field have reached similar conclusions.

Needs More Study

The role of chlorpromazine in long-term therapy of chronic alcoholism is less clear and needs more study before substantial claims can be made. However, clinicians are speculating that it does appear promising in lessening the anxiety and tension experienced by many alcoholics in their struggle to maintain sobriety. It seems to help some of these patients to refrain from drinking and renders them more accessible to psychotherapy.

Given either orally or by injection, chlorpromazine is easily administered. But make no mistake about it, this is a potent drug and should *never* be taken except by prescription and under the supervision of a physician.

RESERPINE

Reserpine is another powerful drug tried in the treatment of acute alcoholism. Some trade names are:

Serpasil, Serpine, Rauwiloid, and Raudixin.

This tranquilizing drug is a purified extract of *Rauwolfia serpentina,* a snakeroot plant used in India for centuries for a wide variety of illnesses including epilepsy, insomnia, headache, fevers and mental illness.

Rauwolfia tablets have been used in this country since 1950 for the relief of high blood pressure. Specialists found that it not only controlled high blood pressure, but was equally effective in calming patients' fears and anxieties. In recent months, reserpine has been employed widely in calming psychotic patients, making them more easily managed. Its use with alcoholics, at least under scientific conditions, has been limited but fairly promising.

New Type Action

Although unrelated in chemical structure, reserpine's reaction on patients is similar to that of chlorpromazine. Here is what one group of scientists said about it: "It (reserpine) has a type of sedative action that we have not observed before," they reported. "Unlike barbiturates or other standard sedatives, it does not produce grogginess, stupor, or lack of coordination. The patients appear to be relaxed, quiet and tranquil. The drug makes them feel as if they simply don't have a care in the world."

Most of the reports on the use of reserpine with alcoholics deal only with its effect on the acute mental and nervous conditions encountered in the "drying out" stage of treatment.

In a Veterans Administration Hospital in Dayton, Ohio, H. Neuer gave reserpine to a group of 29 alcoholic patients having alcoholic psychoses, including delirium tremens. He found that within 24 hours after starting reserpine, the patients stopped "seeing things" and soon were able to be up and around again. Neuer's conclusion: reserpine is effective in shortening the duration of alcoholic psychoses and in simplifying nursing care. He points out that the treatment is aimed only at the patient's immediate symptoms, and makes no claims as to the drug's value in treating the underlying causes of alcoholism.

Another group of researchers treated 24 patients having delirium tremens of the most severe type. In spite of some annoying side effects, such as nausea and low blood pressure, reserpine snapped 21 of these patients out of DT's within 24 hours. The scientists concluded that the drug shortens the time required "to free patients of their post-alcoholic withdrawal symptoms," and releases hard-pressed nursing personnel for other duties. They also speculated that continuing alcoholic patients on daily doses of reserpine might help to relieve some of their anxiety, which often triggers a return to drinking. But a scientific study of this angle was left to others.

Only one such study of reserpine

FUR RAISING EXPERIENCE

WE should be careful to get out of an experience only the wisdom that is in it—and stop there; lest we be like the cat that sits down on a hot stove-lid. She will never sit down on a hot stove-lid again—and that is well; but also she will never sit down on a cold one any more.

—Mark Twain

as an aid in maintaining sobriety can be found. The study took place in New York City in an out-patient alcoholism clinic, offering weekly psychotherapy sessions to patients referred by the courts. Half of a group of 75 alcoholics received reserpine tablets, and the other half got tablets which looked identical but contained no active drug. Neither patients nor therapist knew who was getting which pill. All the patients attended psychotherapy sessions at the clinic for at least 8 weeks. Results: a sizeable portion of patients *in both groups* showed improvement (66 per cent with reserpine and 54 per cent without). The investigator concluded that reserpine offers little additional help to patients in their efforts to control their drinking.

Why They Improved

The important factors in the improvement of both groups of patients seemed to be: (1) the weekly visits to the clinic; (2) the interest shown by the therapist; and (3) the fact that patients received some extra attention in the form of medication, whether it contained any drug or not. More studies of this type are needed, however, before reserpine can be ruled out as an aid in maintaining permanent sobriety.

MEPROBROMATE

Clinical reports on the new drug, meprobromate (trade names: Miltown and Equanil) have shown it to be effective in relieving anxiety and tension states. Since these conditions often are prominent in cases of alcoholism, the drug has been tried for treating alcoholics.

Meprobromate was given to a group of 65 patients hospitalized at Boston's Washingtonian Hospital for acute alcoholism. The response of five patients rated "very good" and was prompt and dramatic. Their severe anxiety symptoms were relieved, and the "shakes" subsided. They slept, ate and felt well. In 33 other patients "good" improvement was noted. Their anxieties diminished, their mood perked up, and the "shakes," though not entirely eliminated, were substantially controlled. An additional 11 patients showed some improvement—certain symptoms were alleviated, while others remained unaffected. Only 16 patients received no noticeable benefit.

Following Hospitalization

Meprobromate has also been given alcoholic patients following hospitalization to help relieve tensions and step up motivation to return to their therapist for regular psychotherapy. Conclusive scientific proof that the drug actually accomplishes these aims is lacking at this time, though studies in this area are in progress.

Dr. Richard Proctor of Winston-Salem, N. C. is currently studying the effects of meprobromate as an adjunct to psychotherapy with alcoholics. He believes that a certain percentage of alcoholics are more apt to drink when they experience anxiety symptoms. They use the sedative effect of alcohol to relieve uncomfortable feelings of anxiety. Dr. Proctor has been having a group of his patients substitute meprobromate for alcohol when they feel their anxiety reaching an intolerable level. He isn't ready to publish any figures yet, but says that "results up to this time seem to be encouraging in selected cases."

Suited for Alcoholics

Meprobromate is apparently well-suited for administration to alcoholics, since it is relatively free of distressing side effects. Principal among its advantages are: (1) It does not disturb the functions of the autonomic nervous system, which con-

trols heart beat, breathing, reflex action, etc.; (2) Does not appear to cause digestive upset or to lower blood pressure; (3) Its continued use over long periods apparently will not result in addiction to the drug.

MERATRAN

Meratran (trade name of the Wm. S. Merrell Company) is a central nervous system stimulant. The action in the body is entirely different from the tranquilizers previously described. It gives a lift to tired, listless persons with feelings of depression, steps up energies to normal levels of alertness, interest, activity and confidence.

Dr. Richard Proctor, whose work has been cited previously, became interested in trying Meratran as an adjunct to psychotherapy with alcoholics. Proctor selected a group of patients whose psychiatric and medical histories, plus psychological tests, indicated that their periodic drinking bouts were brought on by feelings of depression. Some of the patients were given Meratran and instructed to take it when they felt themselves becoming depressed. Others were seen at regular intervals when depression seemed to be developing and Meratran was prescribed. The medication was given for about a ten-day period of time, and when it was discontinued, no withdrawl effects nor "let down" were noted by patients or the physician.

This group of patients, 25 men and 15 women, has been followed for a period of about 12 months. Proctor says the results are "gratifying" for this period of time. Of the 25 men, 18 have remained sober. Of the 7 who did not remain sober, 3 had only one alcoholic episode during the 12 months, while 4 had two or more episodes.

Results showed that among the 15 women, 10 remained sober, one had only one drinking episode, and 4 had two or more.

Formerly, a much smaller percentage of both groups of patients would have been expected to remain sober.

Dr. Proctor is quick to recognize that a large part of these patients' ability to stay sober must be credited to psychological factors. Patients receiving medication as an adjunct to psychiatric treatment may regard it as added evidence of the physician's concern for them, thus promoting a warm, close relationship between patient and therapist. This kind of relationship, however it is brought about, appears to be a key factor in the patients' sobriety.

Not enough time has gone by, Proctor says, to adequately evaluate Meratran as a useful agent in the treatment of alcoholics. Nevertheless, it does look promising when used with other methods of treatment, particularly psychotherapy. Meratran certainly deserves further study.

—GHA

IT'S YOUR RESPONSIBILITY

MENTAL health is never the exclusive responsibility of one profession, neither psychiatry nor medicine nor psychology nor social work. Mental health is like love—it is a goal to be striven for by every one. And though we may receive help from one another, and some persons need special care, each of us must, so far as he is able, take his own responsibility for building mental health.

—Rollo May, in "Pastoral Psychology"

The physical and mental pain that follows the spree is unbelievable . . . except to an alcoholic.



END OF A BENDER

BY JERRY GRAY

From THE THIRD STRIKE by Jerry Gray. Copyright 1949 by Pierce & Smith. By permission of Abingdon Press.

I AM first aware of a great and terrible fear that churns my vitals within me. With sudden clarity I see where I am. I am astride a ship's yardarm high, high above a boiling sea. The ship is rolling giddily. I strive desperately to hang on. I am mocked by a hideous laughter from behind. Turning I am confronted by the horrible spectacle of a giant octopus with satanic human face which inches toward me taunting, "At last! At last you're cornered. Drop if you dare, you jellyfish. Drop if you dare!"

Screaming I let go of the yardarm and plummet toward the seething waters below. Suddenly I see that they are teeming with grotesque upraised tentacles, but I am powerless to halt this mad dive. My stomach overturns as I strike the water.

Down, Down, Down

I lash out blindly only to find that now my right arm and leg are paralyzed. Half incapacitated I strike out futilely to escape the countless black, slimy arms that encircle me. They are crushing me. They pull me down, down, down. My lungs burst.

Then from out of the churning black depths I hear a strange voice—a human voice, strong with the tenor of brusque authority: "Hey, you—cut it out! D'ya hear me? Cut—it—out!"

I hear but do not feel the ringing slap of an open hand against my cheek. An aeon of blackness follows in which wild, jumbled thoughts collide in my head with the force of runaway locomotives.

I open my eyes to a great white mist that rocks and billows crazily like an undulating cloud. In the center of this cloud a light gleams weakly like a ship's mainlight in a fog. Everything is tilted.

Now these surroundings take hazy shape. I take shape. I am in a room—

a small, bare white room—and I am lying on its only piece of furniture, a narrow hospital bed. There is someone seated on the bed beside me, a man, a stranger. His hands are pressed forcibly against my shoulders. He is looking into my eyes.

I try to rise, but he restrains me. Then I feel that my right arm and leg are bound to the wall side of the bed. I go suddenly limp as a wave of nausea sweeps over me, and I lie there trembling like a leaf. I try to vomit but cannot. There is a strange, sickening odor in the heavy air about me.

Man In A White Coat

The strange man beside me rises and walks out into the dimly lighted corridor that I can see vaguely beyond the door. He is a big, shapeless fellow who wears a wrinkled white coat. He shuffles on felt slippers and seems to fade silently into a shifting mist.

I try to rise again as a new wave of nausea retches my insides. But I cannot. Now I see why; there are leather cuffs on my wrist and ankle, and straps from these lead to the underhead and foot of the bed. The bedclothes lie in confusion at my feet. I see that I am clad only in one of those back-tied atrocities that hospitals term nightgowns. It is twisted up about my chest and wet with perspiration. None of this makes sense. None of it is real. Nothing is coherent. I cannot think in a straight line. Everything is jumbled.

I lie there shivering and deathly sick. I want to die at once. The nausea and chills are increasing. I cannot stand any more of this. I want to get away—to escape anywhere—out of this physical hell.

Wherever I am or how I got here doesn't matter, I think. Nothing matters, only to get out of this somehow. I've got to! But they've got me tied down. Who's got me tied down? Why am I strapped naked to this strange bed? What have I done?

A terrible searing fear encompasses me, stronger even than the nausea. "My God!" I cry out into the heavy stillness, "what have I done? What's happened to me that I should be strapped in this bare cubicle with my nerves screaming?" I struggle to recall things. What happened last? I remember . . . What do I remember?

"I was in the park, Battery Park, wasn't I? Yes, that's right. And there was the girl, the girl with the straight black hair and cameo face, the girl who did what I had set out to do. She jumped into the river. She had the nerve! I saw her do it. I remember just how she looked when she took off. She was terrific! She had the courage, the guts, and so would I if these people—what people?—hadn't tied me down. I've got to find out what happened . . . I've got to know . . . I've got to . . ."

"What have you got to do, buddy?" asks the brusque voice again.

"I've got to get out of here," I say. "You've got to unstrap me. I don't belong here. I belong in Battery Park, not tied down here like a rat in a cage."

Let Me Out Of Here

Now I notice the strange man in the white coat beside me. He holds a tincup in one hand and a clean nightgown in the other. Over his shoulder the ceiling light seems to expand and contract like a stubbed toe in a movie cartoon. I want to laugh and point it out to him. I forget the nausea and my desire to get out of here. I do laugh.

"Take it easy, pal," says the brusque voice. "You're going to be all right. You're coming along fine." The voice is not soothing; it rasps on tortured nerves.

"Yeah," I answer wildly, "I'm com-

ing along. Sure, I'm coming along. But where to? You've got me trapped."

"That's right," says the voice, which I now see through a rising mist goes with a face like that of a retired welterweight. "We're in the saddle now, so you just better lie back and take it easy. No more screeching and jumping around. You wake the dead."

"I want a drink," I cry. "I'm the one who's dying around here."

Nice Big Jolt

"I know. All you guys die—like a cat," he says heartlessly. "But cheer up. I've got a nice big jolt for you if you be a good little boy. See, right here." He waves the tin cup. At sight of it desire and nausea fight fiercely within me. Desire wins. I reach for the cup. My hand shakes terribly.

"Just a minute, pal," says the voice. "I've got to get you tidied up first. Now lie still while I uncuff your wrist and change nightshirts. No monkeyshines. Or no drink." He leans over to unlock the cuff, and I can feel the cold bone buttons on his coat like icicles against by abdomen. I get sick again and worry that I won't be able to hold the drink down —that precious, precious drink!

"Sit up," is the order.

I do and become so dizzy that I have to hang on to him. Saliva seems to pour into my mouth and run down my throat in torrents. Now I have the cold shakes so badly that even my teeth chatter. I drop back to the pillow, exhausted but filled with spasmodic twitchings. Now I am too sick to die. I want to die peacefully, not in this hellish torment. I begin to groan. I can't help it.

White Coat puts an arm beneath my shaking shoulders and raises me to a half-sitting posture.

"Here's your drink. This'll straighten you up in short order. Bolt 'er down fast."

"What is it?" I ask weakly. Whisky? I can't drink whisky. I'll throw it right up. Gin is my hell on earth."

"This is a special drink—a new blend. It's better than whisky or gin. But it's powerful, and you got to drink it fast. Just close your eyes and down the hatch. It don't taste like a highball, but it sure does the business." He pushes the cup into my trembling hand. "Fast now," he orders.

The drink is in my mouth and half swallowed before I recognize the hoax. No one who has ever inhaled the fumes of paraldehyde thinks back on it kindly. It is the devil's own brew, which, though it may bring blessed balm to shrieking nerves and oblivion to tortured mind, emits the foul odor of an embalming fluid that hovers ceaselessly in the nasal tract and clings to the mouth for hours in pernicious halitosis. Each ensuing belch reproduces the original nauseous intake. A psychiatrist swears by it, an alcoholic at it.

I Have To Swallow

I fling the tin cup from me and, gasping with indignation, try to spew out what I have not swallowed. But White Coat is ready for this occasion. His hand is under my chin, forcing my head back with a determined expertness that brooks none of my feeble opposition. I have to swallow or choke. I swallow.

"You're a skunk!" I shout at him with tears rolling from my eyes in abject self-pity. "A skunk who sprays paraldehyde from ambush."

"That's a new one to add to my list," he replies. A smile cracks the drill sergeant's expression he's been wearing. To me it is the hated, condescending smirk that the strong so often extend to the weak in a moment of self-righteous satisfaction. It carries no warmth, no understanding,

no sympathy. Now I want pity to add to my own, to swell it into a great, mutual commiseration that will cover my woes like a warm blanket. Now I do not want to die. I want only pity in heaping doses; I want my mother's hand, her soothing voice, her assurance that she understands what is happening to me in the awful moment of misery. I want an hour on a calm sea in the dead of night to settle all these vagrant, painful emotions. I want to cry as a spent, exhausted child cries. I do cry.

How Long?

"How long is this hell going to last?" I ask White Coat as, without resistance from me, he draws the leather cuff tight about my wrist again. "Tell me how long, so I can prepare for it? How long?"

"In about thirty minutes you'll be in bye-bye land." He pulls a blanket up over my shivering body. "Sleep is what you need, bud—lots of it."

"But I don't want sleep. You only have to wake up when you go to sleep."

"Yeah, that's right. Monotonous, ain't it?" There is a sadistic note in his voice. Then, "By the way, what's your name?"

"Who cares?" I retort.

"Not me, bud," he says wryly, "but just in case you kick the bucket, maybe there's someone who might want to know the details."

A dull, heavy weight lowers upon my distracted mind, scattering all incoherence and replacing it with one great thought that seems to bounce about in my skull like a tennis ball.

"So I *am* going to die! And you've just given me the *coup de grace!* You've known it all along! Sleep, you called it. Murder, you mean. Murder while I'm tied down."

I begin to struggle again, wildly, furiously. Might as well go down fighting. Maybe I'll get one sock at this smirking executioner beside me. Might as well . . .

"Cut it out, you!" barks the drill sergeant again, "before I clip you one. D'ya hear? You ain't gonna die. Relax!" He has my free arm in a vicelike grip. I am helpless and seething within. I cannot see him clearly. My eyes are drowning in tears of impotent rage. Then I suddenly go limp again.

"You guys give me the willies," he says scornfully. "One minute you want to die and the next you're fighting to live. Why don't mugs like you make up your minds for once and for all—and do it! All you birds ever do is walk in circles. You're all moods and no guts and before long you're bait for the booby hatch.

"Now what's your name for the records, and where do you live? Maybe you don't know it, but I'm trying to help you, though God knows why."

Hard-Boiled Jailer

His tirade abashes me. I feel small and weak again and very sick. I look for a ray of pity in his expression. There is none. He's just a hard-boiled jailer.

"There's identification in my wallet," I answer, "if you haven't stolen it."

"You had no wallet on arrival here. Not a scrap on you. Clean as a whistle. And don't give me that 'stolen' stuff."

In a flash I remember the wallet and what I did with it. It is on the safe at the Seamen's Church Institute in a large manila envelope addressed to Mother. I remember now. I told the man who looked at me with such a puzzled expression to mail it in five days if I didn't return for it. He told me the whole thing sounded screwy, tried to keep me there while he talked with somebody. I remember running out of the room and down the stairway.

So I tell White Coat about it, what my name is, and that my address in New York is the Institute on South Street. I beg him to let me get my wallet and papers before they are mailed out. I can't let that letter go to Mother now. I said too many things in it. Don't you see?

"We'll see about it," he says. "It won't go out. Relax. How do you feel now?"

"Barely alive—terrible. I'm burning up inside. I've got to have a drink. That stuff you gave me makes it worse, much worse."

"The jitters are leaving you," he says and feels my pulse.

"I can bring them back just by thinking about them. They're only on a short vacation."

"Yeah? Well, don't think. Start counting sheep. Or, with you, maybe mermaids would be better, seeing you're a sailor." He laughs. Again I hate him for being able to laugh, for being well, for being calm and possessed.

"What's your name?" I ask. "And where's your badge?"

"Who cares?" he mimics. Then, as he sees me compress my lips, "I didn't mean that, bud. Just call me Jim." It is easier to subside now. I can sense a slow languor stealing over my body like a quilt of eider down reaching outward to my extremities. I begin to relax. My stomach muscles lose their tenseness, and the nausea is subsiding.

"Where am I, Jim?" I have feared to ask this question because I am not willing to admit that my memory isn't complete. Yet there is a great gap—a great dark spot after much haziness.

"Don't you know, bud—really?"

"No, Jim, I do not. Nor how I got here, nor what day it is, nor what I've done, nor anything. I only know I'm here and tied down."

"I'll give it to you straight, bud. This is Bellevue Hospital, the bug ward. You're under observation. I don't know who brought you. The cops, I suppose.

"After you've had a good sleep, the doctors'll talk to you. You'll be all right, pal," he adds and pats my shoulder. "You got a heart like an ox. It'll take more'n gin to snow you under."

His voice has lost the rasp. I am beginning to feel warm now, and my stomach has vanished. Jim's calm announcement about the "bug ward" and "cops" somehow fails to terrorize me. I simply wish to lie here and welcome a delicious, progressive numbness and watch the lighted fish-eye in the ceiling.

"Jim," I say without fear, "do you think I'm crazy?"

From afar I hear Jim's voice, now grown soft and tired. "I wouldn't know for sure, pal, but I don't think so. Let's worry about that tomorrow."

"O. K., Jim, I'll . . ."

Clouds are enveloping me. They draw me into their warm, soft midst and bear me aloft. Everything is white and clean and peaceful. Somewhere beneath me waves wash languidly against bleached sands. I see no evil faces, hear no still, small voice, feel no fear.

A SOCIAL worker making a door to door collection made the following plea to a housewife: "Would you care to contribute something for our alcoholics asylum?"

"Yes, indeed," said the housewife. "Come back Saturday and you can take my husband."

—From "Folsom Fellowship Newsletter"

UP

THE STEPS GO BOTH WAYS

1. We admitted we were powerless over alcohol . . . that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understand Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

DOWN

1. I decided I could handle alcohol if other people would just quit trying to run my life.
2. I firmly believed that there was no power greater than myself, and anyone who said so was insane.
3. I made a decision to remove my will and my life from the care of God, who didn't understand me anyway.
4. I made a searching and thorough moral inventory of everyone I knew, so they couldn't fool me and take advantage of my good nature.
5. I sought these people out and tried to get them to admit to me the exact nature of their wrongs.
6. I became willing to help these people to get rid of these defects of character.
7. I was even humble enough to ask these people to remove their shortcomings.
8. I kept a list of all the people who had harmed me, and waited patiently for a chance to get even with them all.
9. I got even with these persons whenever possible, except when to do so might get me into trouble.
10. I continued to take everyone's inventory, and when they were wrong, which was most of the time, promptly made them admit it.
11. I sought through concentration of my will power to get God, who didn't understand me anyway, to see that my ideas were best and that He ought to give me power to carry them out.
12. Having maintained my drunkenness with these steps, I can thoroughly recommend them to other alcoholics who don't want to lose their hard won status, but wish to be left alone to practice intemperance in everything they do for the rest of their days.

From ON CENTER

Program Pointers

(Continued from page 3)

families. This arrangement is a complete departure from the experience and attitude of state alcoholic programs elsewhere in the nation. Most states maintain single-purpose, specialty clinics which treat alcoholics only. The Program's director is convinced, however, that as time goes on the North Carolina arrangement will be adopted by other states. Our experience has shown that good therapy *can* be provided in an integrated, all-purpose mental hygiene clinic *when there is sufficient professional personnel available and when that personnel is receptive and enthusiastic toward working with alcoholics and their families.* During the present biennium, two new mental hygiene clinics have been opened. Two more will begin operation during the next biennium. In order to assist these new facilities in their acceptance of the alcoholic as a patient, and in order to help them provide well-rounded treatment for the alcoholic, a slight increase in our budget is requested."

Educational Program

"Because of lack of personnel our educational service has been unable to meet the demands made upon it by the public. Many requests for preventative workshops, institutes, and teacher training courses have had to be declined. Use of the mass media for preventative education has been restricted. The dissemination of literature concerning treatment and prevention has been severely limited because of reduced budget. At the same time, we are receiving increasing numbers of requests for assistance from other state agencies. Health and welfare departments are dependent upon us for their literature on alcoholism. Private groups look upon us more and more as a source of educational aid. Large numbers of clergy and church groups increasingly are seeking our aid in learning more about alcoholism and the contribution the church might make toward eliminating the widespread suffering it causes. The requests for literature, for speakers and teachers by church people con-

ANCIENT WORDS ON HEALING

They do certainly give very strange and new-fangled names to diseases.—Plato, 427-347 B.C.

Patience is the best remedy for every trouble.—Plautus, 254-184 B.C.

There is no witness so dreadful, no accuser so terrible as the conscience that dwells in the heart of every man.—Polybius, 200 B.C.

Whoever cultivates the golden mean avoids both the poverty of a hovel and the envy of a palace.—Horace, 65-8 B.C.

Words are the physicians of a mind diseased.—Aeschylus, 525-456 B.C.

The best of healers is good cheer.—Pindar, 522-442 B.C.

Heaven ne'er helps the men who will not act—Sophocles, 496-406 B.C.

The life which is unexamined is not worth living.—Socrates, 470-399 B.C.

Healing is a matter of time, but it is sometimes also a matter of opportunity. —Hippocrates, 460-377 B.C.

tinue to mount. Yet our resources are limited.

"By state law, the public schools of North Carolina must carry on a program of alcohol education. Our teacher training program is a concerted attempt to cooperate with the State Department of Instruction in carrying out this provision of the law. Intensive summer school courses are held in five of the teacher training colleges. This training program should be extended to other colleges in the State in order that more teachers might be equipped adequately to guide our youth in learning the scientific facts concerning alcohol and alcoholism in the classroom. This extension of mandatory service cannot occur until additional staff is provided. Experience by other states in evening extension courses for classroom teachers leads us to believe that this is another worthwhile medium of teacher training. With the addition of a trained health educator to our staff this avenue of education could be instituted. An increasing number of classroom teachers call upon us for aids to their classroom teaching of alcohol problems. They seek the latest in alcohol educational materials. They are eager for the use of the most recent visual aids as they attempt to carry out their responsibility under the State law. Without



"Look. Why don't you stay sober one evening . . . Just to see what it would be like."

adequate funds to prepare, print, and supply these requested materials, we are unable to meet the demands of the teachers as they call upon us for help. To overcome these deficiencies and to meet the essential demands required of the Program, we are asking for a small increase in our Educational Account."

Voluntary Treatment Unit

"On the basis of patient census during the current biennium, medical personnel at our in-patient hospital for alcoholics at Butner estimate an increase in patient load during the next biennium. Because of the larger number of patients to be hospitalized and treated, costs of operation will be slightly higher. To meet these increased costs, a small increase in the In-patient Account is necessary."

Jail Tragedies

(Continued from page 4)

non-alcoholic, at least in certain localities.

And the irony of it is that the alcoholic, especially if he has been drinking, is usually in worse physical shape and more likely to have an organic disease than his non-alcoholic cellmate. It is a medically recognized fact that alcoholism very often accompanies organic disease. The alcoholic seems particularly prone to peptic ulcers and other disturbances of the gastrovascular organs. He is often the victim of high blood pressure and other malfunctions of the circulatory system, including heart trouble. The practicing alcoholic is almost always suffering from severe vitamin and mineral deficiencies. He is sometimes tubercular.

Not only can alcoholism accompany these diseases and others, but chronic intoxication can effectively mask some of them from early detection.

It seems to us that common human error is not the only unfortunate factor involved in these jail tragedies. Popular attitudes and common misconceptions can, and probably do, enter the picture more often than any of us would like to believe.

If it is the attitude of a large number of our citizens that the alcoholic is always a potential menace to the peace of our communities, who can blame the police for jailing an alcoholic who appears to be intoxicated?

And who can blame them for failing to recognize the alcoholic as a sick person who may need medical attention when even his relatives may take the attitude that "all he needs to do is sleep it off."

The police, as we have said, are only human and can be expected to reflect the attitudes of the communities they serve for better or worse.

There will be fewer jail tragedies of this sort when the public . . . and the police . . . finally discard the last remnants of the old fallacies and deeply ingrained prejudices regarding alcoholics and accept the modern scientific concept that the alcoholic is a sick person who needs, and deserves, help. One other thing: The public and the police will have to take appropriate action.

FILLERS

Licker talks mighty loud when it gits loose fum de jug.

—Joel Chandler Harris

Nothing so needs reforming as other people's habits.

—Mark Twain

I DRINK to drown my sorrows,
Not from idle whim,
But it's all a dismal failure;
My sorrows have learned to swim.

—from ON CENTER



Books of Interest

ALCOHOLICS ANONYMOUS

(Revised)

$4.50
Alcoholics Anonymous
Publishing, Inc.
New York

(Review, copyright 1956 by Journal of Studies on Alcohol, Inc., New Haven, Conn.)

IN April 1939, the first edition of the book *Alcoholics Anonymous* was published. At this time the organization known as Alcoholics Anonymous was 4 years old and boasted a total membership of about 100 men, all of whom had represented very advanced cases of the disease.

When the second (revised) edition of the book came out in 1955, the situation was wholly changed. During the 16 intervening years, a minor miracle had taken place. The A. A. membership had swollen to more than 150,000 recovered alcoholics. About 6,000 groups were scattered over 52 countries. Moreover, the character of the membership was changed. Alcoholics in all stages of the disease—early as well as late, young as well as old—were joining the society. More than 15 per cent of the total were women. In addition to Catholics, Protestants and Jews, there were Hindus, Moslems and Buddhists. A. A. had reached into every level of life; and the vast membership was still growing.

Along with this expansion had come acceptance and respect from professional groups as well as the public at large. Individual physicians and clergymen publicly endorsed the work of the fellowship. Articles about it began to appear in the scientific literature. Then in 1951 the American Public Health Association presented an award to A. A., "in recognition of its unique and highly successful approach" to the problem.

What the first volume of *Alcoholics Anonymous* set out to accomplish—and the second edition is no different in this respect—was threefold. First of all, it sought to establish alcoholism as a bona fide disease over which the individual has little control. He cannot "cure" himself. Will power is a useless weapon in this condition. The alcoholic, however, is commonly as intolerant of this medical view of his malady as is the rest of the world. He will doggedly claim that he can control his future drinking despite monumental evidence to the contrary in the shape of accelerating loss of control. He will fight the truth about his illness right up to the bitter end unless there is outside intervention. It is the task of A. A. to provide just such intervention.

The second purpose of the volume was to describe exactly how A. A. works, what its philosophical principles are and how they are applied to the individual case.

The third aim was to recount how the organization of A. A. came into being, how it developed historically, and how it functions at the present time—as a method, as a group set apart, and as a group relating to the outside non-alcoholic world.

These three goals are well fulfilled

in both editions of the book. The volume begins by describing how the movement got started. In both editions this section is virtually identical. The Preface to the revised edition states that "Because this book has become the basic text for our society and has helped such large numbers of alcoholic men and women to recovery, there exists a sentiment against any radical changes being made in it. Therefore the first portion of this volume, describing the A. A. recovery program, has been left largely untouched."

The opening chapter tells "Bill's Story" — how a New York stockbroker, a compulsive drinker for many years, had been able to stop as the result of a sudden spiritual experience. This occurred after a reunion with an alcoholic friend who had been in contact with the Oxford Group movement of the 1930's. The friend had achieved sobriety through a religious conversion and was eager to convert Bill. Though Bill could not accept all the tenets of the Oxford Group, he became convinced of the need for "moral inventory, confession of personality defects, restitution to those harmed, helpfulness to others, and the necessity of belief in and dependence upon God." In the next 6 months, Bill was able to keep himself sober by working with other alcoholics, just as his friend had worked with him. Whenever he felt an overwhelming urge to drink, he was able to control it by this means. Not until he encountered "Doctor Bob," however, at Akron, Ohio, in June 1935, did he succeed in sobering anyone but himself.

These two men, later recognized as the co-founders of A. A., went to work "almost frantically" on alcoholics arriving in the ward of the Akron City Hospital. Their very first case—a severe one—recovered immediately and became A. A. number 3. The work at Akron continued through the summer, with many failures but an occasional heartening success. Thus the first A. A. group had been formed, although no one realized it at the time. When Bill returned to New York in the autumn of 1935, he was able gradually to form a second small group there. The third started in Cleveland in 1937. By a sort of verbal chain-letter process the movement slowly spread, reaching a membership of about 100 in the course of 3 or 4 years.

"It was now time, the struggling groups thought, to place their message and unique experience before the world. This determination bore fruit in the spring of 1939 by the publication of this volume . . . The fledgling society, which had been nameless, now began to be called Alcoholics Anonymous, from the title of its own book." A new phase was begun at this moment; publicity started to snowball, and membership likewise. In the next 2 years, the 100 grew to 8,000 members.

The society then entered "a fearsome and exciting adolescent period. The test that it faced was this: Could these large numbers of erstwhile erratic alcoholics successfully meet and work togther? Would there be quarrels over membership, leadership and money? Would there be strivings for power and prestige? Would there be schisms which would split A. A. apart? Soon A. A. was beset by these very problems on every side and in every group.' But out of this frightening and at first disrupting experience, a set of unifying principles evolved which have remained in force to this day. "It was thought that no alcoholic man or women could be excluded from our society; that our leaders might serve but never govern; that each group was to be autonomous

and there was to be no professional class of therapy. There were to be no fees or dues; our expenses were to be met by our own voluntary contributions. There was to be the least possible organization, even in our service centers. Our public relations were to be based upon attraction rather than promotion. It was decided that all members ought to be anonymous at the level of press, radio, TV and films. And in no circumstances should we give endorsements, make alliances, or enter public controversies." These were the ingredients of A. A.'s Twelve Traditions. "Today the remarkable unity of A. A. is one of the greatest assets that our society has."

Thus the organization was born and took shape. But how did it win so many followers and friends? What were the elements of its program which set it apart from all other methods of dealing with alcoholics?

First and foremost is the principle that an ex-alcoholic is better able to win the entire confidence of another alcoholic than is any other individual, however sincere. "That the man who is making the approach has had the same difficulty, that he obviously knows what he is talking about, that his whole deportment shouts at the new prospect that he is a man with a real answer, that he has no attitude of Holier Than Thou, nothing whatever except the sincere desire to be helpful; that there are no fees to pay, no axes to grind, no people to please, no lectures to be endured—these are the conditions we have found most effective."

The ex-alcoholic's first duty with a fellow sufferer is to impress on him the gravity and hopelessness of his disease, to disenchant him of the notion that he can ever again use alcohol in a normal way. The medical concept of allergy is often used to describe his abnormal reaction to alcohol—partly to blot out the social stigma attached to alcoholic behavior and partly to make graphic his powerlessness to remedy the condition alone. "We know that while the alcoholic keeps away from drink, as he may do for months or years, he reacts much like other men. We are equally positive that once he takes any alcohol whatever into his system, something happens, both in the bodily and mental sense, which makes it virtually impossible for him to stop."

Thus relieved of moral responsibility for his abnormal condition, the alcoholic is urged to give up his futile struggles and acknowledge the need for help—help in the form of sympathy and understanding from the A. A. fellowship, but eventually help "from a Higher Power."

A. A.'s good-humored approach to the difficulties in this step illustrates another reason why they have achieved so much success. They are the first to recognize that religion may be the bitterest pill of all for the alcoholic to swallow. "But cheer up, something like half of us thought we were atheists or agnostics. Our experience shows that you need not be disconcerted . . . We found that as soon as we were able to lay aside prejudice and express even a willingness to believe in a Power greater than ourselves, we commenced to get results, even though it was impossible for any of us to fully define or comprehend that Power, which is God.

"Much to our relief, we discovered we did not need to consider another's conception of God. Our own conception, however inadequate, was sufficient to make the approach and to effect a contact with Him." As soon as this hurdle can be crossed, the alcoholic begins to feel a new sense of power and direction, provided he takes other simple steps. These con-

sist essentially in self-analysis, self-appraisal, accompanied by the determination to make amends for past mistakes. The 12 Steps which are suggested as a program of recovery stress the necessity of acquiring insight and humility. Through all of this, the conscious effort must be made "through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out."

The 12th and final step is the crux of the matter: "Having had a spiritual awakening as the result of those steps, we tried to carry this message to alcoholics . . ." In practical experience, working with other alcoholics has proved to be the most important and effective way for the alcoholic to insure his own immunity from drinking. It seems to work when other methods fail, just as it worked originally for the two founders of the movement. A great deal of space in the book is devoted to elaborating this theme with concrete suggestions on how the new prospect should be handled. This concept is in a way the essence of A. A. as well as the reason for the steady expansion of the society.

The remainder of the book is given to the personal histories in which various members of A. A.—a cross section of the membership—describe in their own words and from their own points of view how they recovered from alcoholism through A. A. When first published in 1939, the book carried 29 such autobiographical sketches. In the second edition, the personal history section has been revised and enlarged "in order to present a more accurate representation of our membership as it is today." The 37 stories form the bulk of the volume. Almost 400 pages are given over to this purpose.

This, then, is the Alcoholics Anonymous "Bible." Everything that the alcoholic or non-alcoholic reader needs to know about the organization is contained herein. For alcoholic readers the significance of the book is obvious. And because A. A. has demonstrated its value in countless thousands of recoveries, the book is a useful guide for physicians, clergymen, social workers—all who have professional or personal dealings with alcoholics.

THE modern doctor tends less and less to divide the illnesses with which he has to deal into cases of physical illness and cases of psychological illness. He looks instead at the illness as a process in which are mingled physical and psychological events, both of which have to be dealt with. He realizes also, as the homeopathic physician has long ago realized, that different psychological types of men are liable to develop different varieties of physical illness, the aggressive type of man being more disposed to develop cardio-vascular troubles and the regressive type digestive disturbances. He understands also that illnesses are very often purposive in character, that they provide the patient with a way out of a dilemma which cannot be solved in any other way. This being so, the patient will in all likelihood continue to develop illnesses until the basic emotional problem from which they all spring has been uprooted.

—Kenneth Walker in "The Story of Medicine"

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
300 E. Northwood St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husband, or other close relatives of patients.

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INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

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The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

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ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

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NOV.-DEC., 1956

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

A Psychiatrist Looks At Alcoholics Anonymous

Resentment Can Wreck Your Life

Program Pointers

Preventive Education For Youth

Editorial—Hospitalization For Alcoholics

Books of Interest

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

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1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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INVENTORY

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NOVEMBER-DECEMBER, 1956

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Helps Ministers

Obviously, the work of the NCARP greatly enhances the minister's work in the parish; and for that I am particularly grateful. So, many thanks for your contribution to our society and, in advance, for the forthcoming issues of Inventory.

Harmon L. Smith, Jr.
Minister
Grace Methodist Church
Burlington, N. C.

Enjoying Life

Am really enjoying life without drinking. I thought at one time this would be impossible. Have all the praise to make of Butner because it helped me to get a start.

A Former Patient

Information Helpful

Many thanks for the information you are sending to the clergymen of our State regarding alcoholism. I have found the information we have received from you from time to time to be the most helpful in the field.

Bernard Trexler
Pastor, St. Mark's
Lutheran Church
Asheville, N. C.

Fine Publications

You, the editor and members of staff are to be congratulated on the many fine publications developed, which have been a real contribution, I know, in your State, and also to all of us who deal with programs on alcoholism.

Clyde Gooderham
Executive Director
Utah State Board on
Alcoholism

Keep Up Good Work

This will acknowledge the package of materials sent by your office recently to the clergymen in North Carolina. This should be very helpful to all ministers and especially to those who have had little background for understanding this problem. Keep up the good work.

J. W. Lineberger
Pastor
Divine St. Methodist
Church
Dunn, North Carolina

Constructive Work

Please accept my sincere thanks for the brochures and pamphlets which you sent me at my request. I am grateful for being placed upon your mailing list. Your work is the only truly constructive work being done with alcoholics, outside of A.A.

Rev. John A. Gray
St. Timothy's Episcopal
Church
Wilson, N. C.

Helpful Treatment

Butner was the most helpful treatment I have ever received. Thanks a million and, please, continue to help sick alcoholics.

A Former Patient

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

OUR readers may remember that last year the NCARP joined with the three professional nursing organizations in the state to co-sponsor a couple of two-day educational institutes for nurses. We were pleased at the enthusiastic reception and good attendance which these institutes enjoyed. We recently had a request from the nursing section of the State Board of Health that we meet with them to discuss the possibility of holding similar institutes again this year. Representatives of the nursing section said they had heard many favorable comments from those who attended last year, and that many nurses who did not attend have expressed the hope that they will be given another opportunity. Consequently, we are now in touch with the North Carolina League for Nursing and the North Carolina State Nurses Association to see if they would share in sponsoring another nurses' institute on alcoholism again this year.

Speakers Bureau

Requests coming into this office for speaking and teaching on alcohol subjects continue beyond the ability of our staff to meet them. As a partial remedy to this situation, we are going to try to organize a Speakers Bureau so that others in the state who are trained and prepared to help us fill these requests will do so.

If this arrangement can be worked out, the NCARP staff hopes to devote more time to working with professional groups, concentrating on supervisory level people, in the belief that our educational efforts will thus be broadened in scope.

Call For Assistance

We hope that many of our Yale Summer School alumni will be able to assist us in filling speaking engagements. Many of them have told us that they are willing and even anxious to lend us a hand in our educational program, whenever it is reasonable and convenient for them to do so. We appreciate their expressions of interest, and expect to call on some of them for assistance in the near future.

In the meantime, we do not want to discourage requests for speakers on alcohol problems, for in many instances we can refer the requests to someone in the same communities from which they come.

The NCARP hopes to be in a position again this year to offer a limited number of scholarships to the Yale Summer School of Alcohol Studies. Inasmuch as the number of scholarship applications has been steadily increasing from year to year, it will be necessary to set an earlier dead-

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AMA COUNCIL URGES HOSPITALIZATION

ONE of our chief concerns here in North Carolina, and elsewhere, is the need for a wider acceptance of the acutely ill alcoholic as a legitimate patient in our general hospitals. An alcoholic experiencing withdrawal symptoms following a prolonged bender, is just as sick as many of the patients who are admitted to the hospital with other types of "socially acceptable" illness. And yet, hospital treatment is often denied to them solely on the basis of their diagnosis of alcoholism.

Denial of treatment is based on the old idea that alcoholics make obstreperous, uncooperative, hard to handle patients, and are better left to stew in their own juice. As one hospital administrator put it to me, "We've got no place for drunks here. We need all the beds we can get for sick people."

Recently, we have had some hopeful signs that this attitude and its resultant policies toward alcoholics is undergoing change. Our readers will remember that a 1955 survey of general hospitals in North Carolina showed that 76 per cent of these hospitals would, with some qualifications, accept an alcoholic patient *when requested to do so by a member of its medical staff.* It appears, then, that the local physician, staff member of the community general hospital, is in a unique position to influence that hospital's admission policies toward alcoholics.

No hospital can long resist pressure from its medical staff members to admit patients whom they have judged to be in need of hospitalization. As more and more physicians come to accept the alcoholic as a legitimate patient, we can expect to see an increasing number of hospitals follow suit.

Obviously, members of the medical profession are in key positions to gain hospital admittance for acutely ill alcoholics. Do they realize their position? Are they willing to exercise their influence in behalf of alcoholics? The answer in both cases seems to be an unqualified, yes. The best evidence of this is contained in a report issued by the Board of Directors of the American Medical Association, published originally in the AMA Journal.

The report is significant for two reasons. First, because of its source—the American Medical Association is one of our most in-

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VOL. VI, No. 4 INVENTORY NOVEMBER-DECEMBER, 1956
ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The goal of alcohol education should be a mature personality, able to face up to reality.



PREVENTIVE EDUCATION FOR YOUTH

BY CHARLES W. GAUGHAN
ASS'T TO THE DIRECTOR
MASSACHUSETTS DIVISION ON ALCOHOLISM

EDUCATORS should be concerned with what might be called the "traditional" alcohol education in the public schools. Many teachers of alcohol education in recent years have been revising and extending the scope of such material in line with modern educational practice and recent knowledge of alcohol problems resulting from current research.

Chief among the criticisms of the traditional alcohol education was the fact that so much emphasis was placed on the effects of alcohol on the body. Lasting and serious effects on the body were felt by only a negligible number of all those who drank. School age youngsters, interested primarily in how relatively small amounts of alcohol might affect them, were offered little regarding the influence of alcohol on individual and social behavior. Moreover, much of the physiological material put out has been factually incorrect, not information but misinformation.

Another considerable criticism of the traditional method is that it fails

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to meet the student on his own level of interest. High school students are more aware of the criticisms of members of their own age group than they are of adults. The questions which they ask as a result of discussion of the problem refer to the effects of drinking on current relationships which are important to high school age students.

Despite the fact that state law requires instruction on the facts about alcohol, alcohol education has usually been characterized by neglect and inadequacy. School administrators avoid repercussions that might come from dealing with a controversial subject. They likewise find that there is a dearth of materials and information to use in alcohol education. In most instances there is technical compliance with legal requirements without real effort to present a good program relevant to the needs and interests of students.

Based On Fear

However, the most serious criticism to be leveled at traditional alcohol education is that it has been based on fear psychology. The idea has been to tell children about the horrible results of drinking and scare them away from it. Fear has been laid on good and thick with the expectation that some of it will be impressive enough to stick with them. Just as building fear is not considered good education procedure, teachers who work with both younger children and teen-agers realize that it is almost impossible to scare children away from anything which they really want very much to do. To create fear about an activity sometimes gives it a compelling fascination.

It is easily pointed out that the home and other experiences of many youngsters disprove to them the suggestion that death or disease is the lot of anyone who ever takes a drink. On the other hand the real factual dangers of any kind of drinking are seldom taught in a clear and impressive manner.

The view of alcohol education, which is gradually superceding the older approach, stresses factual correctness as the key concept of the program. Exaggeration for the scare effect is not used. Instead an attempt is made to get at the real problems of students in the circumstances of their daily environment.

Frank Discussion

Another necessity for good alcohol education is to bring students into it actively by allowing frank discussion and questioning, and the use of problems and projects worked out on student initiative. There are perhaps some school subjects where it is sufficient simply to present information. In alcohol education we deal with a subject on which students, at least by the time they are in high school, already have strong attitudes, and often bad misconceptions of fact. Examples of drinking adults, often very bad examples, are part of their common experience. They are frequently under pressure from contemporaries to drink. They must all arrive at decisions about what they are going to do now and in future years. These situations are not adequately met by simple recitals of facts or by telling young people what we



adults would like to have them do.

As an expression of the drinking situation as many young people see it, their question might be, "If the effects of drinking are so terrible, why do so many people, who are obviously intellignt, healthy, and successful, do it?" It is the type of question which has to be answered some way if alcohol education in the schools is to have a real effect on the thinking and behavior of young people.

Many Problems

In a modern complex society it is evident that alcohol presents not one, but many problems. The use of alcoholic beverages in any community is accompanied by behavior on the part of some drinkers which involves the entire community, non-drinkers as well as drinkers. Intoxication, traffic accidents, court and jail situations arising from drunkenness, neglect of family and job responsibilities, debts and disorganization of the individual in relation to the community, are some of the problems which have become a burden to society. Herein lies the unique aspect of the alcohol problem. The fact that excessive use of alcoholic beverages takes a direct and tragic toll of other individuals in the community and society, makes it imperative that a solution be found. Since our social tensions and complexities will tend to increase rather than decrease, they, therefore, tend to intensify this problem.

The most obvious and immediate need in alcohol education is well-prepared teachers with an adequate background in this area. Such teachers need to be familiar with reliable sources of information and materials in order to have the ability to organize and direct instructional units. They need to have scientific, objective answers to the questions and problems which students raise concerning alcoholism. Every administrator in the public schools and teacher training institutions, in turn, faces a dual responsibility. He must first develop an in-service program for teachers and second, he must guide them in developing sound alcohol education as an integral part of educational learning experiences.

Goal Of Education

The essential objective of alcohol education is the same goal as that for all education, a maturing or mature personality capable of adjusting to the realities of his environment. Such a personality will have less need to escape from reality. It will have techniques to help release the tensions and the frustrations which sometimes cause the immature or arrested adolescent personality to seek such escape mechanisms as bridge addiction, overeating or alcoholism. The school's emphasis on sensitivity to individual needs or problems, on proceeding at the individual's rate of

COMMENTARY ON FAMILY LIFE

OUR most important educational influence is the family we are brought up in. And there are many, many families whose effect on their children is a terrible and ruinous one. Most families develop strong emotional stress. There are many exceptions, certainly, but by and large, our families are educational flops of the first water.
—From HOW TO LIVE 365 DAYS A YEAR, by John A. Schindler, M.D.

learning, and particularly on helping the maladjusted child, tends to remove possible causes for and may, in turn, prevent alcoholism in later years. This may prove to be the most positive contribution the schools can make in alcohol education.

Meeting Their Needs

Good programs of guidance, specialized activities such as club work, social and square dancing, team and individual sports with carryover value in after-school leisure time activities, the encouragement of camping experiences, creative activities in art, music, and handicrafts, are all part of a positive program for prevention of alcoholism. In short, the school which is meeting the actual needs of youth has gone a long way toward the solution of the alcohol problem. If this positive environment assumes the additional responsibility of providing students with the latest facts regarding the total problems of alcoholism, a satisfactory basis will be established for the development of a constructive alcohol education program. Each school must provide, of necessity, sufficient up-to-date library and classroom reference materials for the use of students.

A major weakness lies in the emphasis on alcohol itself, rather than on the causes of alcoholism. In the language of medicine, the symptoms have been treated rather than the disease. Science and medicine point out that the basic issue in the problem is the personality which has been unable in some areas to adjust satisfactorily to its environment. If the use of alcohol could be prevented, the personality problem would still be present and other escape mechanisms would be substituted.

Unbiased Facts

The causes and reasons for excessive drinking must be understood before the resultant physical, mental, social and economic problems to the individual and to the society become meaningful to the student. The understanding of reasons and causes for alcoholism, however, will not guarantee prevention. If students as citizens are to make an intelligent decision regarding this problem (as well as many others which face our society) they must have access to ample, sound and unbiased information. Only through such an approach can they develop an understanding of the cause and possible solutions of the total problem.

PARENT-CHILD RELATIONSHIPS

WE know that the parent-child relationship is of great importance for the development and the molding of the personality. In male alcoholics we frequently find the combination of an overly strict harsh father and an overindulgent, overprotective mother. It is no coincidence that the alcoholic is frequently an only or the youngest child. The most serious cases of permanent mother dependency and by no means only among the alcoholics, we find in only sons of women who were disappointed in their married life and sought recompense by projecting all their love on the only son. He had to satisfy their emotional needs by remaining in the close mother-child relationship forever.

—From TREATMENT OF THE ALCOHOLIC, by Fritz Kant, M.D.

A Psychiatrist Looks at Alcoholics Anonymous



He calls AA "this generation's best example of social progress."

BY EDWARD J. DELEHANTY, M.D.
CHAIRMAN
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THIS subject deals with the mechanisms of how Alcoholics Anonymous really works; the psychotherapy of AA, in other words. Maybe this methodology is fundamentally too mysterious or esoteric for anyone to explain and I think that many AA's will agree with me that we cannot always explain how they or some other person finally "got" the program after stumbling around it for some time.

However, before we try to assign a reason for the success of AA, we probably should take stock of what we are trying to accomplish; what we have to work with and to work on; and what the end results are that we are attempting to accomplish. Most everyone is in accord that the totality of AA is certainly more than sobriety or merely the solution to abnormal use of beverage alcohol. Furthermore, we have various types of alcoholics and various and sundry types of drinking patterns, so that any standardization of "cure" of a drinking problem is obviously out of the question though I am sure at times people look to medicine and

From an address delivered to the University of Utah School of Alcohol Studies, Salt Lake City, June 21, 1956. Reprinted by permission.

psychiatry and AA for simple short cuts to a solution of a drinking problem.

It may be of some aid in understanding AA to analyze whence it came and how. And how were the Twelve Steps agreed upon and by whom. Were they handed down to Bill W. and Dr. Bob like the Ten Commandments were to Moses or did some pious religious in the quiet of his study concoct these steps from his reveries? No! The Twelve Steps of AA were in essence an evolution of man's experience for many ages. They are truly the Christian code restated so that they can be more practically applied by those who are virtually driven by the necessity of escape from an overpowering compulsion to do so.

Changed Concept

Alcoholics Anonymous has done much to change the concept of the disease, alcoholism. Bill W., a cofounder of this organization, tells how his work with alcoholics and with himself and his own problem succeeded when the emphasis was changed from sin to sickness. This is indeed remarkable when we remember that great stress is placed upon a moral and spiritual revival to overcome the compulsion to drink. Bill W. had been converted as a result of contacts with former drinking companions who had become "dry" under the influence of the Oxford Group. When Bill felt lost and abandoned and prayed for help, he had an experience similar to that of St. Paul and Mohammed. He saw a great white light and he was enveloped in a great wind which was of Spirit and not of air. Ecstasy, relief, and a sense of freedom followed. Bill remained dry, though not without many trials and temptations, and he tried to "reform" other alcoholics.

Sick Men

When he told them of his spiritual experience they kidded him about his "hot flash" and quenched his evangelism. Soon he realized that sin and reform had little to do with the situation. Alcoholics were sick men, at least men who had sickened with the struggle with life. They needed conversion, and usually they needed medical attention before moral support became effective. Man cannot live by bread alone but he does need the bread before he can do anything else. As other alcoholics recovered and joined in the endeavor, the movement spread by "chain reaction" until today AA is known around the world and scarcely any hamlet is small enough not to harbor at least one who has recovered from the



WHY do people drink? A great deal has been written on this subject. The answers have varied extremely and queer hypotheses have been advanced. It should, however, not be difficult to understand why people drink. Analysis of the alcohol effect on the emotional aspect of the personality gives a simple explanation. The mood is fundamentally changed. Alcohol produces euphoria and increased confidence in one's own mental and physical powers. Inhibitions are overcome. A feeling of well being is created; self esteem is boosted. Conflicts and worries are forgotten and life as a whole appears brighter. That is the reason that people drink.

—From TREATMENT OF THE ALCOHOLIC, by Fritz Kant, M.D.

disease, alcoholism.

It is only natural that the sciences, medicine and psychiatry, should try to dissect and analyze the fundamental or underlying reasons why AA should work when science and religion had failed throughout the years. So it might be of interest to try and evaluate some of the "whys" of AA's success.

Nothing New

That the Twelve Steps are not an innovation is suggested by the fact that they can be found in essence in other places. The most notable is the outline for religious retreat as given by the Jesuit Order of priests. But we need not look too far for possible origins as Bill himself has told us that he got his ideas from the Oxford Movement and the Oxford Tenets are:

1. Admitted he was powerless to solve his own problem. (Step 1)
2. He got honest with himself as never before; made an examination of conscience. (Steps 4, 8, 10)
3. He made a rigorous confession of his personal defects. (Step 5)
4. He surveyed his distorted relations with people, visiting them to make restitution. (Steps 9, 11)
5. He resolved to devote himself to helping others in need. (Step 12)
6. By meditation he sought God's direction for his life and help to practice these principles at all times. (Steps 2, 3, 6, 7, 12)

These Tenets antedate AA by many years and I am sure you can see the Twelve Steps of AA in the six I have given you, and can visualize the same result if applied in the AA manner. That is one reason that I say that the Twelve Steps are but a practical means of applying principles long ago given us by the Bible, the scriptures, i. e.: by God himself. We do know that these Twelve Steps evolved through the experience of the early members of Alcoholics Anonymous and if they were typical alcoholics, there was much argument and heated discussion amongst the "midwives" at the birth of these suggestions. This leads to the first principles of AA, the Twelve Steps.

Now, what is it that these Steps are to perform? First of all we have, as a rule, an individual who is suffering from a physical allergy to alcohol combined with an obsession to use the very poison or allergen that is responsible for his illness. In addition he is usually a very sick personality. A sick personality in the following ways:

1. He has an unconscious need to dominate (yet is dependent)
2. He has a hostility feeling tone. Guilt. (defense against inferiority)
3. He has a sense of loneliness and isolation.
4. He has a simultaneous feeling of inferiority, and yet has a failure of self-criticism.
5. He has a striving for perfection (superiority)
6. There are racial or cultural fac-



tors (Irish vs. Jewish)

These are more or less categorical characteristics of the alcoholic personality. Getting down to descriptive terms, we are pretty much in agreement when we describe the alcoholic as being emotionally immature. He has an inflated Ego. He shows dependency. He is impatient. He is intolerant. He shows much neuroticism, tension, anxiety, fear and worries. He is often, but not necessarily, atheistic or agnostic, or his spiritual ideals and concepts are warped or misshapen.

No Easy Task

Comes now the problem of what to do about this "meat-ball" that optimistically calls itself a personality and how to get it across the gaping chasm of reorganization to a place where some of its attributes are Maturity, Objectivity, Humility, Patience, Tolerance, Self-reliance, Honesty, and Spirituality. No easy task, you will say, and I agree with you since no one ever completely attains the goal. However, some degree of success is necessary and the improvement that is constantly and daily made is more important than the absolute degree of perfection attained.

For purposes of making a diagram and also to simplify and explain the Twelve Steps, I have attempted to epitomize each step in one word. These I submit to you for consideration and revision.

Step One. INSIGHT. *Keen discernment or understanding.* This is particularly true as to POWERLESSNESS over alcohol and the mess into which our lives have deteriorated. Irreversibility.

Step Two. SURRENDER. *To yield to the power of another.* Various steps or degrees: Half-hearted acceptances, compliance. Surrender, both emotional and intellectual, is a necessary adjunct to Insight.

Step Three. DECISION. *A settling or terminating, as of a controversy, by giving judgment on the matter.* This usually after trying everything and everybody else. What is left to turn to but God? It certainly is a settling after controversy, since the alcoholic has had nothing else but controversy for a long time, with himself and everyone else.

Step Four. INTROSPECTION. *To look into or within, as one's own mind.* How else can we truly inventory unless we look into our own minds? Who else but God can look therein unless we do it ourselves? This introspection must be verbalized either in writing, which is preferable, or in speech which leads us to the next step. This crystalizes our thinking.

Step Five. CONFESSION. *Avow, acknowledge, admit, as a fault or debt.* Psychoanalysis calls this "mental catharsis." Medicine says, "personality defects" must be eliminated thru accurate self-knowledge. This is best done by openly admitting and putting into words our short-comings. Religion has recognized the value of this confession process for centuries, and says, "The alcoholic must make examination of conscience and a confession or a moral inventory and a frank discussion."

Step Six. SUBMISSION. *Act of submitting, especially surrender of person and power to the control of another.*

Step Seven. HUMILITY. *Freedom from pride and arrogance.* This step may not necessarily confer humility, but we must find humility before we

can take the step. When we admit we have shortcomings and are ready to give them up we are certainly striving towards humility.

Step Eight. INVENTORY. *A catalogue or schedule, hence an itemized list of goods with their estimated worth.* The alcoholic must list the assets as well as the defects. Sometimes the neglected assets that a person fails to utilize constitute a graver fault than sins of commission. The New Testament upbraids the man who was given one talent and he carefully buried it until the time of accounting and was given no credit for his mere preservation of the talent. So it is incumbent upon us all to utilize, for the common good, those talents which we have.

Step Nine. RESTITUTION. *Restoration of anything to its rightful owner.* Possibly reparation would be a more apt word, since many times we have nothing to restore to anyone except their peace of mind and to make amends for the grief and heartache we have caused them. Our continued sobriety and personality change may be the sole chance for restitution to those nearest and dearest to us and whom we have harmed the most. Material reparation may be insignificant to moral restitution, and an abject apology and admission of wrong-doing even to those to whom we owe material things may be of much greater value to them than the material itself.

Step Ten. REORGANIZATION. To again become systematized or constituted into a whole of interdependent parts. Unless there is continuation of the finding of *daily* defects (resentments, hates, pettiness, envy), there can be no reorganization. Thru the prompt admission of error there is growth intellectually and morally —the facade of pretense is eliminated and the entire effort can be devoted to constructive thinking and accomplishment.

Step Eleven. SPIRITUALITY. *The moral feelings or states of the soul.* Thru constant prayer and meditation, humility becomes common-place, effort at improvement is routine, "not good—but improving". Anxiety is removed thru the feeling of an omnipresent personal Being whose will supercedes our own. Faith as a cure for fear.

Step Twelve. CHARITY. *Act of loving all men as brothers because they are sons of God. Good will to the poor and the suffering.* The joy of living is the theme of AA's twelfth step, and action is its key word. It is thru the recovering alcoholic's attempt to help others that he often is aided in his own insight and introspection. To hear his own feeble excuses being used by someone else is a shock and a revelation to him. The fact that he is working with others gives him a sense of accomplishment and of "belonging". His narcissistic ego gets a thorough defiation as he attempts to help others. His own petty difficulties become obliterated when he sees the graphic picture of where he might be should he again attempt to take one drink.

In recapitulation we can add these further interpretations of the mechanism of the Twelve Steps:

FIRST AA: "Say, I just found out that I have the equivalent of a college education."

SECOND AA: "Yeh, how come?"

FIRST AA: "Well, Mr. Wilkins had to go to Yale to learn about alcohol, didn't he?"

1. *Admission of defeat.* "Hitting of bottom or being ripe". Abrogation of our own inflated ego and hence the initial effort towards humility.

2. *Belief.* Overcoming of *defiance* and further puncturing of that hypersensitive Ego. The incorporation of a potent *father-figure* which implies "we are no longer alone", and fear and anxiety begin to fade.

3. *Willingness.* Willingness to go along with the reversals and frustrations and disappointments that God has in store for us, recognizing that there is a master plan behind these seeming set-backs. "Thy will be done."

4. *Inventory.* Acceptance of our assets and liabilities, hence *objectivity* which is the basis of *honesty.*

5. *Confession, catharsis, or what will you?* Further deflation of the Ego which maintains and strengthens humility because if we tell someone and ourselves of our faults and shortcomings, we need not fear someone exposing them. Exposure and embarrassment have been the alcoholic's bugaboo during his drinking.

6. *Surrender.* Which aids in objectivity and honesty and complete confidence in an omnipotent Power.

7. *Humility.* To admit our shortcomings and dependence on God.

8. *Restitution.* The act of the mature individual. The immature personality sees no need for restitution.

9. *Forgiveness.* We must learn to forgive ourselves if we expect it from others.

10. *Perseverance.* Continued improvement.

11. *Prayer and meditation.* More things are wrought by prayer than this world dreams of. Prayer for the knowledge of God's will for us. Not *bargaining* with God to give us what we would like to have. He knows. It might be well to mention it in our prayers but add, "Thy Will Be Done". If this one phrase could be totally and completely and continuously incorporated in our lives, I am sure we would walk as saints upon the face of the earth.

12. *Action.* Carrying this message to others, but more important, keeping these principles in action in our own affairs. I would go along with St. Paul when he says, "Faith without good works is dead". When we have good works in action we have CHARITY in essence. Action is the magic word.

Giving Insight

What AA actually does is to help the alcoholic establish insight by acquaintance and association with other alcoholics in their sober and reflective moods and help him to put his understanding of himself to useful purpose. The alcoholic is emotionally immature and he has never learned to face the realities of life or has forgotten how to do so. Consequently, he is disturbed and defeated when realities are difficult and adversity occurs.

In addition, AA is essentially a form of group therapy—like recovery, it also provides identification

GOAL IS TOTAL ADJUSTMENT

FURTHERMORE we must keep in mind that abstinence is not an isolated goal we pursue in treating the addict. As much as this may appear prominent in a discussion of alcoholism—psychotherapy approaches the personality as a whole in an attempt to bring about an emotional adjustment of the patient to himself, the family and community.

—From TREATMENT OF THE ALCOHOLIC, by Fritz Kant, M.D.

with those who have been successful (If he can do it, so can I.)

Its many slogans: 24-hour program of living, Easy Does It, Live and Let Live, provide surcease from anxiety and fears and provide continuing support in the battle against the resurgence of the inflated Ego. The very anonymity of the fellowship is a safeguard against any "big-shotitis" which might develop. Anonymity is a means to humility, not a cover-up. It is an Ego-deflator. Without God we are nothing. Anonymity places principles above personalities. We can accomplish much if we don't care who gets credit for it.

All of us, whether alcoholic or not, can take a page from the AA lesson and remember, "If we do not have that which is above us, within us, we shall surely succumb to that which is around us".

Why does AA succeed when other methods have failed?

The world is well acquainted with the fact that Alcoholics Anonymous is the first generally successful method of dealing with the abnormal user of alcohol. Actually, more people recovered than we recognize before the advent of Alcoholics Anonymous. They were unrecognized because when they recovered from their alcoholism, they "went underground", in a manner of speaking, since neither they nor their families could tolerate the stigma that would be attached to having an ex-drunk in the family group. Thus the ability to now count noses among the recovered alcoholics makes the recovery rate seem relatively greater than it actually is. I do not mean in any wise to belittle the success of AA; I am rather trying to keep our thinking straight. The group therapy achieved by AA at times puzzles even psychiatrists. As early as 1943, Dr. Harry Tiebout reported to the American Psychiatric Association, "After observing personally for years the interesting effect upon my patients of the AA program and having watched at close range numerous other examples of their work, I feel it highly imperative that we, presumably open-minded psychiatrists, view wisely and long the efforts of this group of recovered alcoholics who are now achieving so many remarkable recoveries in our field. At first I was amazed and chagrined when AA accomplished a change in a patient who was a failure under my therapy, now I am amazed and astonished when the patient fails under the AA program."



It Works

The psychiatrist considers alcoholism as symptomatic of a disease. AA says, "Your drinking is a disease," which is probably wrong *but* it works and nothing succeeds like success.

The psychiatrists have attempted to be understanding, helpful and tolerant of AA. May the good members of AA understand that attitude and not conclude that someone is trying to erase their prerogative of having the best example of social progress in this generation and the foremost haven of hope for those who suffer from the disease—alcoholism.

FEELINGS OF INFERIORITY

A normal person sees his real inadequacies, learns to eliminate or accept them

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SOME degree of feelings of inferiority exists in each of us—without exception. We feel inadequate in our work; we feel doubt as to our ability as parents; sometimes we feel worthless; occasionally we feel sinful and no good in general. It is perfectly normal to have these feelings to a mild degree and occasionally. It is not reasonable (and most uncomfortable) to feel inferior most of the time or even occasionally with an intensity that results in brooding and strong guilt feelings.

A healthy person recognizes real inadequacies or inferiorities within himself and learns to act to eliminate these or, when necessary, (and this is often) to accept them—without exaggerated feelings of worry and guilt.

Some people are unable to accept themselves and have developed habits of exaggerating and fostering their feelings of inadequacy to a degree which causes illness, sometimes very severe illness.

There are some factors common to most of our lives which cause us to develop feelings of inadequacy. The occurrences take place, as a rule, long before we become adults. Here are some examples:

1. As a child, being physically smaller than, weaker than, and intellectually inferior to the other members of the family inevitably produces feelings of inferiority.

2. In addition, most children are taught to think of themselves as inferior to adults to whom they must give in. Too seldom are children treated as people with rights of opinion and action.

3. A majority of children, at home and at school, are constantly pushed toward standards of perfection of behavior and achievement which are beyond them—even beyond the abilities of many of the adults who are guiding them. This can only result in feelings of inadequacy.

4. A large majority of adults have developed habits of concealing many

normal feelings and of inhibiting many minor actions for the sake of "dignity". By comparison, children are more natural. Yet often they are made to feel, by precept or example, that the expression of normal feelings is wrong. This causes them to think that there is something wrong with having the feelings and inferiority results.

5. All of the above feelings become habitual and usually result in a tendency for the adolescent, in his search for adulthood, to exaggerate his faults. Thus, feelings of inferiority may be added to.

6. Some children are either babied by their parents or domineered over and belittled. As a result they do not mature in self-dependence and self-confidence. The result is a feeling of inadequacy and inferiority.

7. Children who are different in intelligence, dress, physique, or in other ways usually encounter prejudice with resulting exaggeration of their feelings of inferiority.

8. Physical illness, especially if prolonged, limits normal activities and associations and adds to normal feelings of inferiority.

Developing Habits

These and other happenings in our lives develop habits of feeling inferior. Soon the reasons for the feelings are forgotten and we are aware only of the uncomfortable feeling that we are not as good as others or that we are not as good as we ought to be.

The following are examples of feelings or actions which occur in all of us as a result of a lack of a high degree of self-acceptance and self-confidence. Some of us develop these feelings or habitual ways of acting to a degree that we stay constantly worried or anxious.

1. Sometimes we withdraw from people and activities in order to avoid situations which make us feel inferior. Then we sense that we are escaping and feel inferior because we regard escape as cowardly.

2. Sometimes we try to act superior in order to conceal our feelings of inferiority—even from ourselves.

3. We may domineer over others in an attempt to convince ourselves that we are not really inferior.

4. In the same manner we may press children to become perfect as a sort of sop to our own feelings of inadequacy.

5. We may try to compensate for personal feelings of lack of worth by striving hard for recognition and achievement in work, in accumulating money, in one of the arts, etc.

6. Being dissatisfied with ourselves, we may become angry with ourselves and punish ourselves by failing—or we may take this anger out on others by being hypercritical, for example.

7. Sometimes we develop the idea that others are against us. As a result we become sullen or aggressive toward people. This, of course, does set them against us.

8. Feelings of inferiority cause us (all of us) to feel fleeting moments of pleasure when others are hurt or embarrassed. We fail to recognize that these are normal feelings and that we do control them. As a result we are ashamed and add to our own feelings of inferiority.

9. Feeling inferior, we may become super-sensitive to the normal affronts of everyday life and even imagine affronts where none exist.

10. Lacking self-confidence, we spend too much time thinking that if we had done differently things would be better. We feel guilty and concentrate on the past, thus, decreasing our present activities and efficiency.

11. Seeking to feel superior we seek others for scape-goats when anything goes wrong. Prejudice toward other races, religions, etc., is partially

the result of our own feelings of inferiority.

12. Some of us become unable to accept the occurrences of failure which are a part of everyday life. We become "success addicts" and feel comfortable only when stimulated by success.

All normal people have some of these reactions to their own feelings of inferiority. Most of us can learn to eliminate some of our feelings of inadequacy and add to our self-confidence and self-acceptance. Here are a few suggestions.

Everyone Has Them

Perhaps the most important step in easing feelings of inferiority is to recognize that we, along with all other people, have these feelings and that they affect our actions. Having accepted as a fact that feelings of inadequacy exist in all of us we may then be able to differentiate between those feelings which arise from real inadequacies (lack of knowledge or skill, for example) and those feelings which have resulted from influences over which we had little control. Some of these have been mentioned on pages one and two. Once we have clearly and honestly faced our own feelings we are in a position to accept, ease, or eliminate many of them.

When real inadequacies exist, as they do in all of us, we have two courses of action. First, we may examine our standards of self-performance to see if they are within our ability to achieve. Many times we expect too much of ourselves, in general or in some specific lines of endeavor. When this is true, we are unable to measure up to our own ideals and we feel frustrated and inferior. We may find it necessary, as well as difficult, to lower our personal performance standards to a point where they become realistic in terms of our abilities.

Second, we may be able to study and practice to increase our competencies in some areas of life where we feel inadequate. Speaking to groups, meeting new people, teaching, reading, knowledge of child growth are examples of areas in which we may feel inadequate and in which we can, with effort, improve.

The business of overcoming feelings of inferiority based on such experiences as those listed previously is more difficult, because deeper and more subtle feelings are involved. Often the reasons for these feelings have been forgotten and only the emotional attitudes and habits of feeling inferior remain. If we recognize that these habits originated in factors beyond our control, we may be able to ease our feelings of self-blame and guilt—with the result that we no longer find it quite as necessary to punish ourselves with painful feelings of inadequacy. As a result we become free to ease or eliminate some of these feelings and habits of inferiority.

At this point we may begin to develop the habit of concentrating on the present rather than on the past or the future. Constant attention to

DEVELOP A HOBBY

A FASCINATING and creative interest apart from your work is an absolute essential for happy living. Two of our basic needs are the needs for new experiences and for creative effort. A good hobby supplies them both.
—From HOW TO LIVE 365 DAYS A YEAR, by John A. Schindler, M.D.

worry and guilt about acts of the past reduces time and energy for attention to the business of today. And it is the business of today, handled as it arises, that develops our feelings of self-confidence and self-acceptance.

Sometimes feelings of present and past inferiority cause us to dwell too much on dreams of the future in which we hope for the success which we think has eluded us up to the present. This habit of thinking also results in the consumption of time and energy which are needed to handle adequately the work and fun of the present.

Do It Now

Many of us who feel inferior develop a habit of limiting our activities and of putting off many of the things which we must do—more particularly the things which we would like to do. We need to concentrate on the development of a habit of "do it now" in order to avoid a habit of thinking in a circle and brooding. Self-confidence and self-acceptance will follow.

A particular aspect of this is of major importance. Let us do more of those little, harmless, enjoyable things that we have always wanted to do, but which we have been afraid to do. Buy the red coat; join the group in "barber shop" singing; tell that joke; take that trip; stop and look at those flowers instead of hurrying on; eat the chicken with your fingers—and lick them. Any one of these little acts is unimportant, but performing these and the like will help to develop a freedom of expression which is often lacking in people who feel inferior.

Going Outward

Increasing our efforts to go out toward others with expressions and acts of friendship will help to develop a friendly attitude. As a result others will return friendship and there are few better cures for feelings of inferiority than having a large number of friendly acquaintances.

An important result of increasing friendly associations may be that we will talk with less reserve to others, and they to us. Thus, we can learn that these feelings of ours are universal and that we probably exaggerate the importance of them within our own lives.

Maintaining vigorous physical health will contribute to lessening feelings of inferiority. Particular attention may be necessary to nutrition, exercise, recreation and relaxation.



SOCIAL WORKERS CAN HELP ALCOHOLICS

Their tools include: a basic understanding of alcoholism, willingness to accept the alcoholic as he is, and a personality capable of sustaining a warm, flexible relationship with patients.

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PROBLEM drinking has been with us far longer than the profession of social work. Throughout many ages other professional groups, notably the medical and the clergy, have struggled with little general success to find a way of helping those involved in problem drinking. With the beginning of professional social work many social workers added their efforts to those of the other helping professions but with the same sense of failure to both patient and therapist.

Then Alcoholics Anonymous came along about twenty years ago, followed by the work of the Yale University School of Alcohol Studies. From these we have gained a body of knowledge and understanding which has enabled thousands heretofore neglected, rejected or overlooked to become rehabilitated or, in medical terms, to find not cure but recovery.

Here in our own community medicine slowly began to apply these new tools and skills; industry became acutely concerned; reform institutions started programs of rehabilitation, and education has shown interest in prevention.

A Social Problem

What of social workers? Have we as a profession concerned ourselves sufficiently about a problem which is in great part a social one, which plays a major part in the breakdown of family life and is in turn caused in great part by upset, disturbed or negative relationships within the family? I do not believe we have, either to the extent that other service professions have, or to the extent that is necessary if we believe that this illness is not to be treated purely as a physical one but as one in which the person is also emotionally, spiritually and socially ill.

This then brings us to the subject



matter of this paper, which is to define problem drinking for social workers and to show what it means in their work.

Who then is the problem drinker? How can we distinguish him from other people who drink? Are we as confused in our identification as many in the community who label anyone who gets drunk an alcoholic? The social worker must be able to differentiate, for purposes of treatment as well as interpretation in the community, between those who drink at all and those who are alcoholics.

Definition

For our purposes the alcoholic may be described as a person whose drinking in any continuing or regular way is upsetting the stability of his life or his home; he may be described as the person who is unable to have a satisfying life without the use of alcohol; the person who is unable to face the demands or responsibilities of life without an increasing dependency on alcohol; as the person who is basically insecure and unhappy, seeking to relieve the pain of living through the use of alcohol.

Today as a result of numerous articles most people are paying lip service to the belief that the alcoholic is a sick person. It is one thing to be able to accept this fact intellectually, however, but quite another matter to accept it emotionally. With this is closely mingled or interwoven our inability to be as objective about this as we are about other social ills. There seems to be a relationship between our attitude now and our lack of concern or our inability to give constructive help in the past.

There does not seem to be any clear cut reason for this but perhaps there are a few factors worthy of consideration, any one or all of

which may be responsible: our cultural, historical or individual conditioning to the use of alcohol or to drunkenness; our preconceived, and still active, ideas of its being a moral problem or one which demands a moral judgment of the sick person, such as historically we gave to relief recipients or consumptives; our conflict about the place of alcohol in our culture or our individual lives; our fears, conscious or unconscious, about the relatedness of *any* drinking to alcoholism; our very lack of knowledge and experience of an illness so different from all other illnesses.

How It Differs

At this point I should like first to consider this last factor, namely, how this illness differs from others. It differs from others in that, except for the acute stages, the person is up and about; he has no well-defined diseased area; he is often successfully carrying on with a job that calls for skill and training; he is sometimes managing to carry responsibility in the home.

In this illness, in contrast to others, both the ill person and the community resist recognizing it.

It is an illness that brings feelings of shame to the family and causes them to resent, ridicule or ignore the suffering person; that causes feelings of guilt, remorse and self-condemnation in the sick person himself. It is an illness that increases the sick person's feeling of inadequacy, depletes his slight store of self-confidence and adds new fears to those that were in part responsible for his initial dependency on alcohol.

Where do we see another illness in which there are so many relapses or acute stages? An illness which makes a person lie, steal, cheat, hurt those closest to him, or throw away all that seems to be of value to other people? Where do we find another illness in which the ill person has to give up the only thing that has seemed to offer him release from pain and security in life in order to get well? It is an illness that affects the total person more than any other illness, and yet in which the sufferer more strongly resists or denies the need for help and tends to believe, or tries desperately to believe, that he can cure himself.

Complex Illness

Alcoholism is a complex illness that has many hidden aspects, and only one readily recognizable aspect—the regular or periodic drinking bouts—an aspect which looms so large, creates so many problems in and of itself that it is small wonder that families, and often those who are trying to help the alcoholic, see alcohol as the one cause of alcoholism and never get far beyond this.

The patient is considered ill only when he is severely intoxicated and the tendency is, between bouts, to act towards and expect behaviour from him that we would expect from

PERSONALITY OF THE THERAPIST

IN any psychotherapeutic relationship the personality of the therapist is often of greater importance than the method used. This is especially true in the treatment of the alcoholic and success or failure will depend to a large extent on the therapist's skill in approaching the patient and gaining his confidence.

—From TREATMENT OF THE ALCOHOLIC, by Fritz Kant, M.D.

a well person. The very fact that his behaviour between bouts so often has a pseudo-wellness to it fools us again and again into believing that he is capable of responding normally to the demands and pressures of society and his family and those who may be trying to help him.

Dependent Person

Behind the pseudo-wellness, the rather likeable, interesting personality, the abilities and relative degree of success on the job, the above-normal or average intelligence, what do we see? We see, more often than not, a very dependent person who has come into adulthood ill-prepared by his earlier experiences in life to cope with adult experiences; a person who finds it hard to relate to others, who has few inner resources, interests or hobbies, who is easily upset, hurt or frustrated, and who acts out his impulses; a person who has little self-confidence, who is overly concerned about what people think of him and who has fears real and imagined about his place in life and other people's affections—in short, a person who is emotionally immature and insecure.

So much for our understanding of the sick person. How can we help this person? Above all we must respect him as an individual worthy of help, no matter what condition he appears in. Florence Hollis has said "one has to like people very much and be convinced of their essential dignity and worth as human beings in order to get past the dirty and unlovely exteriors of some clients".

We must meet his request for help quickly, with warmth and readiness to give help; we must be able to let him know quickly that we like him and understand his desperation and his mixed feelings about coming to us for help; let him know that we understand his conflicts about treatment or about giving up the one thing that has given him comfort and release from tension; we must recognize the fears he brings, fears of having to give up his independence, fears of being further rejected, condemned, or fears of what is going to be done to him.

As with the disturbed child we may need, in the initial stages, to give words to these fears and feelings, so that he knows that *we* know how he is feeling before he gives in to the impulse to run away. If his need to leave or withdraw is great because of coming to us under too great pressure or because he still is unable to face giving up alcohol, we must be able to help him leave with just as real a sense of our interest in him as though he were going on, and with some real awareness of the ways in which we can help him when he is ready to come back.

Often this recognition of his right to make his own decision, along with the warmth of his reception, is the turning point in his thinking about himself and his problem, and even though he may not come back for a month, or even a year, he more often than not does come back.

Presenting Problems

Lastly, we must be aware that often the problems that he presents first may be very threatening social or emotional problems incurred as a result of his drinking. Only when these have been met and he has some tangible evidence of our desire to help him can he move onto consideration of his real or basic problem.

Here then are some of the necessary factors involved in helping the ill person to begin to use help, either ours or that of someone else to whom we may refer him. What is involved in the continuing contact? First of all we must recognize that the contact is likely to be a long supportive

one, involving endless patience and countless interviews which may have to be maintained whether we refer him to a clinic, a physician, a clergyman or to Alcoholics Anonymous.

Just as in a clinic setting where the patient needs, and is encouraged, to form relationships with a variety of people (in spite of the fact that one particular person may be responsible for his formal treatment) so in the community he needs several different sources of support. We must slowly be able to help him to move out to and make use of these other sources. Unless we know them well and believe in their ability to help him, whether it be clinic, physician or clergyman, we cannot truly help him lose his fears or make the best use of such contacts.

Unique Difficulties

A continuing relationship with an alcoholic presents unique difficulties and hazards, elsewhere encountered in some respects only in work with emotionally disturbed children. (In no sense, however, does this mean he should be treated as a child or that the relationship can be the same as that with such a child). We must, however, understand and expect that the alcoholic will come to his experience with the social worker full of mistrust and fears, and with a constant need to test out our interest in him.

This means, therefore, that we must not only move out to meet him more than half-way but we must be prepared to sustain a warm, less formal, more flexible relationship than is normal to other professional relationships.

The relationship must be one in which he can readily see and feel our love and respect for him no matter what his behaviour; which can accept his broken appointments, the broken promises, the distortions of truth, the relapses, the swings of mood and the overt hostility toward us when we don't or cannot do as he wants us to; which imposes few limits and which allows him to see us, when possible, whenever he needs to.

Slowly, very slowly, within a relationship such as he has not likely experienced before, he may become able to proceed from the known to the unknown; he may not only gain a new understanding of his illness but become able to control it; he may begin to regain, or find for the first time, a sense of his own worth; he may begin to face reality, to solve some of his social and emotional problems; he may, in short, begin to gain satisfactions and joys from a way of life that is not dependent on alcohol.

Indirect Help

No definition of this problem would be complete without a word about the indirect help that can and should be given. This may be done (with the patient's consent) through interpretation to employers or others in the community. More often it is with the wife and family of the sick person. This is not just a matter of interpreting the ill person or his behaviour; in fact very often such a method, if used first, only brings greater resentment and greater resistance to chang-



ing the attitudes which, though they do not cause the alcoholism, play a very real part in relapses or continued drinking.

We must bring to the wife some of the same understanding of *her own* problems as we do those of her husband, recognizing that wives of our patients very often have great needs of their own, which may in part have led to their marrying a sick person in the first place but which certainly have increased and been exaggerated through years of living with him.

Wife's Needs

We know, for instance, that she more than likely brought to the marriage great dependency and affectional needs, as well as a good deal of conflict about sex. (Incidentally, withholding of the sexual relationship is the most often used, as well as the most often carried-out threat, used by wives towards their sick husbands. We can readily see how this affects the sick person as well as the total marital relationship). She came to marriage with her own needs only to find that she was denied the satisfaction of them because her husband's needs were too great.

A wife's own emotional dissatisfaction, the demands to meet his needs, the unpredictability and shame of his behaviour, the constantly recurring social problems and the growing disturbance of the children, have left her physically and emotionally depleted.

As we see her she is full of mixed feelings, fears and attitudes, and reluctant to give up the adjustment she has made to her situation, by which she has become dominating, nagging, threatening, punitive or indifferent. In some instances she has subtly encouraged his drinking because of her own needs or fears. Sometimes she demands or almost dares those helping her husband to succeed where she has failed and at other times begs us to work a miracle.

Sometimes, too, she is desperate for help but has as many resistances to using it as the sick person has himself. There is little positive value in trying to gain her cooperation in the patient's treatment until she feels our genuine interest in her as a person separate from her husband, and sees tangible evidence of our ability and readiness to help her with her own very real problems.

In the initial stages a wife may only ask for, or use, specific direction as to what she should do in such matters as taking a drink with her husband, pouring the liquor down the sink, protecting him from the results of his drinking, feeling ashamed of him, or reasoning with him, when he is intoxicated (to all of which the advice is "don't"). She may at first only use her relationship with us to get rid of her extreme anxiety and hostility. However, as she feels the

THOUGHTS ON MATURITY

MATURITY brings with it a rich concern: how to make the living of others more enjoyable. With this concern, horizons, vision, and sympathy broaden. The person with such maturity is not living in a little closet, grasping and pulling everything possible into its dark confines. He is roaming the sunshine and the great wide world, finding other people interesting and worth the effort of knowing and giving.
—From HOW TO LIVE 365 DAYS A YEAR, by John A. Schindler, M.D.

worker's acceptance she will be able to begin to work more positively on the total problem.

When a trusting relationship has been established, help should be given not only towards gaining knowledge of the illness and its formal treatment, but also towards her own attitude about drinking, about the illness and the man she cares for.

Helping The Spouse

The help should have as its goal not just rehabilitation of the sick person but also a lessening of her conflicts, anxieties, tensions and frustrations, so that she can lead a more satisfying life with or without her husband's recovery, more adequately meet the children's emotional needs so that they will be as little damaged as possible by the fact of having a father who has the illness, alcoholism; can make a decision to separate or stay with her husband, not in anger or desperation, but having worked through her feelings on the matter with someone who brought to it a measure of objectivity.

Most wives, it has been found, do not really want to leave their husbands even though they threaten to do so or appeal to us for help in doing so. When she first comes for help a wife is usually just as divided in her feelings about leaving her husband as the patient is about giving up his alcohol.

Realistic Appraisal

If, however, she is determined to do so, our acceptance of her decision, and a thoughtful appraisal of what is involved in separation, may often help her to face realistically the implications of a life on her own; may help her to recognize her true feelings in regard to her husband as well as her desire to try, with help, to find the way to a more satisfying, or at least a more tolerable, life together.

The most difficult things for a wife to accept emotionally are the fact that her husband's behaviour is the result of an illness rather than a lack of affection for her; the fact that his sobriety alone will not likely end all her problems or bring the satisfactions they are both seeking in their marriage; the fact that the children have been as much, if not more, affected by the difficult parental relationships and their mother's hostility toward their father, as by his excessive drinking. As she becomes more sure in her relationship to the worker and the tension in the home relaxes she may look for indirect help with the children and the problems they are presenting.

Our Own Attitudes

This definition of problem drinking and its meaning to social workers would be incomplete without a look at our own attitudes which were mentioned earlier. How do we really feel about people suffering from this illness, and are we able to recognize we still may have feelings that are affecting our ability to help them? Do we so hate, and are we so repulsed by, the effects of the illness that we can't help transferring our feelings to the person who is ill?

Do we, even with our own intellectual knowledge and outward acceptance of this illness, have so much feeling about the use of alcohol in any way that, under the guise of helping the ill person, we react unconsciously, as does society, in a punitive, authoritarian or moralizing way? These are questions which each of us can answer for ourselves, but positive help for the person suffering from alcoholism depends in great part on our answers to them.

To sum up, the problem may be defined according to our knowledge and understanding of the illness, of

the ill person, and of treatment methods; of our best casework skills given with a warmth and reaching-out beyond what is called for in other relationships; of our freedom from basic prejudices, misconceptions, fears and moral judgments, as well as from any personal problems relating to the use of alcohol.

Last, but not least, it is defined in terms of a personal faith in the redeemability of every human being, so that we ourselves may not give in to the feeling of hopelessness so often engendered by the sick person as well as by society, so that the person suffering this illness may be enabled to find through our recognition of spiritual values the way to his own, without which he will never be completely well.

The Editor's Page

(Continued from page 4)

fluential and respected professional organizations. Secondly, because it throws the weight of that organization unequivocally on the side of those who regard alcoholism as a bona fide medical problem, and the alcoholic as one who is entitled to and often needs hospitalization. We think the principles outlined in this report are important enough that we are reprinting them in their entirety, as follows:

"The problem of the hospitalization of patients with the diagnosis of alcoholism has been considered carefully by the Council on Mental Health and its Committee on Alcoholism. A report and resolution on this subject was submitted to the Board and approved for presentation to the House of Delegates for its action. The statement follows:

Among the numerous personality disorders encountered in the general population, it has long been recognized that a vast number of such disorders are characterized by the outstanding sign of excessive use of alcohol. All excessive users of alcohol are not diagnosed as alcoholics, but all alcoholics are excessive users. When, in addition to this excessive use there are certain signs and symptoms of behavioral, personality and physical disorder or of their development, the syndrome of alcoholism is achieved. The intoxication and some of the other possible complications manifested in this syndrome often make treatment difficult. However, alcoholism must be regarded as within the purview of medical practice. The Council on Mental Health, its Committee on Alcoholism and the profession in general recognizes this syndrome of alcoholism as illness which justifiably should have the attention of physicians.

One of the most consistent complaints of physicians who wish to care for these patients is that many hospitals will not admit such patients with a diagnosis of alcoholism. Many feel that these people are intractable, uncooperative, and difficult to handle. Because of their untoward behavior, hospital authorities feel that they are not equipped to take care of the medical treatment of such overactive patients. Where such patients are unruly and uncooperative, this attitude is understandable. However, for many of these sick people who express a wish to be treated in a general hospital, it has been generally found that cooperation is forthcoming and that no special attention or equipment is necessary for treating these patients. Hospitals should be urged to consider admission of such patients with a diagnosis of alcoholism based upon the condition of the individual patient rather than a general objection to all such patients. Such objections have been very frustrating for physicians who wish to

treat these patients and often discourages them from taking a greater interest in alcoholics.

The Council on Mental Health, therefore, urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic alcoholism should not be considered as an illness which bars admission to a hospital, but rather as qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency.

In support of the above statement, the Council is of the opinion that:

1. Alcoholic symptomatology and complications which occur in many personality disorders come within the scope of medical practice.

2. Acute alcoholic intoxication can be, and often is, a medical emergency. As with any other acute case, the merits of each individual case should be considered at the time of the emergency.

3. The type of alcoholic patient admitted to a general hospital should be judged on his individual merits, consideration being given to the attending physician's opinion, cooperation of the patient, and his behavior at the time of admission. The admitting doctors should then examine the patient and determine from the history and his actions whether he should be admitted or refused.

4. In order to offer house officers well-rounded training in the general hospital, there should be adequate facilities available as part of a hospital program for care of alcoholics. Since the house officer in a hospital will eventually come in contact with this type of patient in practice, his training in treating this illness should come while he is a resident officer. Hospital staffs should be urged to accept these patients for treatment and cooperate in this program.

5. With improved means of treatment available and the changed viewpoint and attitude which places the alcoholic in the category of a sick individual, most of the problems



Horace Champion

As this issue goes to press, Inventory is losing the services of its Editor during the past four years. Horace Champion has resigned his editorial duties to enter the field of free lance art and writing. We of the NCARP staff are very reluctant to give him up.

Only rarely do we find an individual who is equally gifted as a journalist and as an illustrator. Horace Champion possesses both talents in liberal measure, and he has employed then unstintingly for the enjoyment and benefit of Inventory readers.

In addition to having more than his share of talent, Horace is a very likeable guy who has made many friends during his stretch as Inventory's Editor-in-Chief. We are certain that we speak for all who know him, either personally or through this magazine, when we say, "Well done, Horace, and best of luck!"

formerly encountered in the treatment of the alcoholic in a general hospital have been greatly reduced. In any event, the individual patient should be evaluated rather than have general objection on the grounds of a diagnosis of alcoholism.

It is recognized that no general policy can be made for all hospitals. Administrators are urged to give careful consideration to the possibility of accepting such patients in the light of the newer available measures and the need for providing facilities for treating these patients. In order to render a service to the community, provision should be made for such patients who cooperate and who wish such care.

In order to accomplish any degree of success with the problem of alcoholism, it is necessary that educational programs be enlarged, methods of case finding and follow-up be ascertained, research be encouraged, and general education toward acceptance of these sick people for treatment be emphasized. The hospital and its administration occupy a unique position in the community which allows them great opportunities to contribute to the accomplishment of this purpose. It is urged that general hospitals and their administrators and staffs give thought to meeting this responsibility."

Program Pointers

(Continued from page 3)

line for applications this year. The earlier deadline will allow the scholarship committee more time in which to evaluate the applications, and will enable us to submit our list of recipients to Yale officials in plenty of time for administrative action.

We wish to emphasize once more that the Yale School is *not* a clinic for alcoholism. It is for professionally trained persons whose work brings them in contact with the occurrence and prevention of alcohol problems.

Asheville Committee

A year ago last October, the Asheville Citizens Committee on Alcoholism, then in its infancy, invited NCARP staff members to participate in an intensive public education campaign in the Asheville area. This campaign was the kickoff for what the Citizens Committee hoped would eventually develop into a community alcoholism program. During the ensuing year, the interest of the group has mounted, and new people have joined them. They seem now to have developed enough strength to launch some community service project aimed at the control and prevention of alcoholism. This desire to do something concrete prompted the Citizens Committee to invite Dr. Kelly and myself to Asheville recently to discuss with them some of the directions which their endeavors might take.

Enthusiastic Group

We spoke at a meeting to which all members of the Citizens Committee as well as the interested public had been invited. An enthusiastic group of about 60 persons attended. Dr. Kelly outlined some specific activities in which a local committee on alcoholism could engage with the expectation of some positive results. I tried to point up the relationship which might ideally exist between a local program and the state program, stressing such things as how to avoid duplicating services, maintaining good liaison, and drawing clear lines of responsibility. Believing that many of our readers will be interested, we hope to expand on some of the points made by Dr. Kelly and myself in a forthcoming issue of *Inventory*.



Here's an emotion that can disturb your physical well-being, make yourself and others miserable. In fact

Resentment can wreck your life

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BY J. WILLIAM BURRIS

WE all know people who manage to make everyone around them miserable with their grievances and indignant displeasures. The slightest imagined offense on the part of a member of the family or a friend or even a total stranger triggers a mounting toll of resentment that becomes intolerable for all concerned. And there is almost never any logical explanation for these turmoils of resentment.

There is Mr. Brown across the street, for instance, who always insists upon having his eggs "sunny-side up." Yet one day he went into a tantrum when his breakfast was prepared to these usual specifications. For some reason, unexplainable to Mr. Brown, himself, this was one morning he would have preferred his eggs "over easy." Of course he made no advance mention of this fact to Mrs. Brown; he felt that she should have guessed it. By evening the incident had "snowballed" into a major crisis. Mr. Brown had convinced himself that his wife didn't love him, never had, and was in cahoots with the rest of the world against him.

However, this conviction wasn't a

hundred per cent, and therein was the rub. He was faintly aware that he had fabricated the entire affair and that he was the one to apologize, not she. Not being able to do so, he multiplied the original guilt.

If this type of behavior seems juvenile and inexcusable, it must be remembered that, to the victim, these resentments are very real indeed. This type of person can compound a mere idea or thought into a very real and painful situation.

As an example, let's look at the man who has a flat tire on the highway. Having no jack, he is forced to walk three miles to the nearest service station to borrow one. About half way there, and for no apparent reason, the thought comes to him that the man at the station won't let him borrow his jack. The further our hero walks, the more he broods about not being able to use the jack, and the more resentful he becomes. When he finally gets to the station he is fit to be tied. His answer to the attendant's polite query is: "Keep your d-m jack! I didn't want it anyway." Ridiculous reasoning for an adult, to be sure.

Affects Body Functions

However, this emotion of resentment doesn't end with faulty reasoning. It also affects our physical well-being. Doctors base their knowledge that emotion plays an important part in many types of physical illnesses on facts with which most of us are familiar. All of us have experienced the effects of emotions on bodily functions—a tight feeling in the chest, blushing when embarrassed, or having our hearts pound and our hands perspire when we are excited. These are all normal reactions of the body to a given situation, and are beyond the control of our will power. They generally disappear when the cause is removed. Bodily changes occur because emotions really mean for us to act.

When resentment occurs, it makes one tense. When this happens, it in turn leads to physiological and chemical changes in the body. Adrenalin is released which causes the heart to beat more rapidly. The muscles of the heart and intestines contract forcing more blood into circulation. The rate of breathing is increased, all of which is meant to gear the body for action.

Supressed Feelings

Resentment is sometimes so difficult that the person surpresses his feelings altogether, and he is no longer conscious of them. Often what seems to be a purely physical illness stems from a hidden wish to accomplish an end quite different from the one demanded by the situation, and one of which the victim is completely unaware. The little boy who vomits before attending his first party is an example of resentful protest against something that he does not really want to do.

Physical distress can often be a kind of body language to express suppressed resentment. Some of our common expressions concerning this body language of resentment are: "He burns me up!" "He gives me a pain in the neck!"

To illustrate this point, let's look at the case of Julia B—. She was a young woman who suffered physical distress in swallowing and finally had to consult a physician. No organic cause could be found. But she revealed many facts of her life to the doctor which gave him a clue to Julia's distress. She was a mild person and her family and friends had always taken advantage of this side of her character. "Julia will do it!" was a stock-in-trade solution to any of the family's problems. She never protested aloud, but inwardly she became resentful at the injustices

she was forced to swallow. Her physical symptom was an expression of what she was unable to put into words, or even admit to herself. Her bodily language said, in effect, "I can't swallow that stuff!"

Few people can afford to entertain a lot of grudges. Getting even with people who have been mean to us, or even brooding about it, can be a costly hobby. Revenge may be sweet, but you don't get it for nothing.

How then, in certain situations, can you keep from feeling resentful and want to get even. What are you supposed to do when someone humiliates you—either in public or privately?

First of all, you should make sure that the offense was deliberate.

Taking Action

If you are sincerely convinced the offense was deliberate, take action immediately to protect your interests. Don't brood! Fight back if you are justified! Nobody should let himself be pushed around. There are too many doormats in the world as it is.

Many times, however, the question of self-defense isn't involved at all. Say for instance, you have been harmed through the stupidity of another. A stupid person cannot help his stupidity no matter how much you wish he would do something about it. The damage has been done and you certainly won't make it any better by tensing up with resentment and clenching your fists. Relax! Deliberately slump in a chair, or even lie down. It is hard to stay tense in these positions. Remember . . . *you're hurting yourself more than anybody else by harboring resentment!*

There will be an occasional situation when our resentment will graduate to a river of anger, which must have an outlet. Any attempt to keep it bottled up can hurt us mentally and physically.

I have a friend who treats anger as a river. His theory is to write down each little stream of resentment that feeds the river and dry it up. He says, "Dry up the tributaries of resentment and you dry up the river."

The transition from hurt feelings to resentment to anger can have far-reaching effects. The following example may prove a trifle far-fetched, but, I believe, amply illustrates the point:

Two sailors, one Norman and one English, had an argument in the Port of Payonne because of a resentful remark. The argument led to a fight during which the Englishman stabbed the Norman with his knife. The local magistrate failed to take action so the Normans applied to their king who told them to take their own revenge. They put to sea and seized the first English ship they came upon and hung the crew and their dogs to the same mast. As a consequence, a war was fought to satisfy revenge.

Let's not let resentment make war on our physical and mental well-being!

Here then, briefly summarized, are some suggestions to help you combat this emotion of resentment:

Don't brood! Brooding allows distortion to creep in!

Relax! Lie down, or slouch in a chair. It is hard to stay tense in these positions.

Make a list of everything that irritates you and dry them up one at a time.

Learn to laugh at your mistakes. Laughter can act as a safety valve to discharge what, at the time, seems unbearable tension.

Say out loud in private, "Don't be an idiot!"

Remember . . . by harboring resentment, *you are hurting yourself more than anyone else!*

There you have it—let's see you go to work on that resentment!

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

North Carolina State Library
Raleigh

JAN.-FEB., 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

The N.C.A.R.P.—Progress and Problems

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Goals of Education-Treatment-Research

North Carolina's Fight Against Alcoholism

News From 'Round The World

One Community's Answer

Program Pointers

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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Educational Director

S. K. PROCTOR
Executive Director

DESMOND McNELIS, M.D.
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INVENTORY

VOLUME VI NUMBER 5

JANUARY-FEBRUARY, 1957

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

CONNECTICUT. The Yale Summer School of Alcohol Studies will hold its fifteenth session at New Haven this summer during the period from June 30 to July 25. In attendance will be professional men and women who have an interest in alcohol problems, their causes and solutions. The NCARP is again offering scholarships to the Summer School for as many qualified applicants as funds will permit. Lecturers for the school will include specialists from the fields of medicine and psychiatry, religion, education, and public health. Specialized problems will be explored in seminars, with informal group participation following many of the lectures. Included in the curriculum will be topics on the physiology of alcohol, related alcohol problems, treatment of alcoholism, and theories on the causation of alcoholism.

NORTH CAROLINA. The NCARP will again sponsor this summer, four sessions on facts about alcohol for teachers and prospective teachers. The Summer Studies will be held at and in conjunction with the following colleges: North Carolina College, Durham, June 10-21; East Carolina College, Greenville, June 17-21; A. & T. College, Greensboro, June 24-July 8; Appalachian State Teachers College, Boone, July 22-August 2. The course of study is designed for better understanding of the sociological, psychological and physiological problems which arise from the use and mis-use of beverage alcohol. Each will offer three quarter-hours college credit. For details, write to Director of Admissions at any of the four colleges.

FLORIDA. The dedication of Florida's brand new Alcoholic Rehabilitation Center was held February 6-10 at Avon Park. State officials were guests at the dedicatory exercises and at the presentation and tour of the Center's facilities. The Center is dedicated to the recovery of those who need a helping hand in solving their alcohol problem. Treatment is based on group therapy meetings, open discussions and individual consultation.

NEW JERSEY. The New Jersey State Legislature in January enacted legislation empowering each of the twenty-one counties of the state to set up clinics for treatment of alcoholics.

NORTH CAROLINA. The 1957 Convention of Alcoholics Anonymous in North Carolina will be held in Greensboro, May 24 through May 26. And something new has been added. Industrial leaders throughout the state have been invited by AA to attend seminars to discuss problems of alcoholism in North Carolina industry, and clergy and lay leaders will devote their time to the problems of alcohol relating to the church. In addition, specialized sessions will be held for AA wives, families and friends. Approximately 1200 AA members from the Carolinas, Tennessee and Virginia are expected to pour into the King Cotton Hotel, convention headquarters, during the meeting. This promises to be a most interesting program.

CHELTENHAM, ENGLAND. The second AA Convention in the United Kingdom will be held here again this year on May 11 and 12. Admission charge? One willing heart.

NORTH CAROLINA. "The Caseworker's Role With The Alcoholic" has been selected as the topic for state-wide meetings of the North Carolina Caseworkers Association, to be held March 13 and 14. Ten North Carolina cities will be hosts to the sessions: Waynesville, Tryon, Gastonia, Greensboro, Durham, Southern Pines, Southport, Washington, Halifax and Winston-Salem. At the request of the State Welfare Department, the NCARP is making arrangements for the speakers and the program.

RALEIGH. All AA's, families and friends are cordially invited to attend the Raleigh Spring Open Meeting of AA to be held Friday, March 29, at 8 PM in the Josephus Daniels Junior High School Auditorium. The Rev. John C. van D., of Morris Plains, New Jersey, popular minister and AA member will be the principal speaker. The meeting is sponsored by Raleigh AA Groups. No registration fee or collection will be expected.

LONDON. Here's good news for loners! "Wee Whispers," a new newsletter for loners, is now being published in London. December, 1956, brought forth the first issue. "Wee Whispers" is a monthly report of the doings of AA and is written especially for those who cannot attend AA meetings. The editor requests your letters, loners, telling how you've grown in AA despite your isolation. To subscribe to "Wee Whispers," write to Norman F. T., c/o Monomark, BM/AUSA, London, W. C. I., England. You will receive "Wee Whispers" free of charge.

KANSAS. A new series of articles on alcoholism has been started in 109 Kansas newspapers. The primary purpose of the series is to discuss alcoholism objectively—its history, personality problems, rehabilitation, etc., and to acquaint the people of Kansas with the purposes of their Alcoholism Commission.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

IN this issue of INVENTORY, I am coming to you with an appeal for help. The NCARP is at a point where important decisions must be made as to the future growth and development of the Program. Without your assistance, the NCARP may be allowed to stagnate.

We are devoting this issue of INVENTORY almost exclusively to the NCARP. We will take a backward look at its progress in the past seven years. We will look at our shortcomings, our successes, our past and our future.

As you know, public opinion about alcoholism has changed substantially in the past seven years and, as in any association dealing with such a complex problem as alcoholism, the NCARP has had to constantly study, plan, re-evaluate and re-examine its resources and organization. We have had to make new plans and objectives to coincide with the public's changing attitudes toward alcoholism. We have known that we must either go forward or go backward. We could not stand still. This going forward has meant continuous re-setting of goals and objectives.

A great deal has been learned in these seven years, and by association with other professional people from other state programs, it has been our opportunity to measure our own attitudes and organization. We have seen the development of a number of other state alcoholic programs over the nation, a number of which looked to us in their early stages for suggestions and assistance. Many of these state programs have now exceeded us with more adequate resources and funds available to them with which to expand.

In the September-October issue of INVENTORY, I explained to you the philosophy and rationale under which we operate. As you know, our state program is divided into three essential components: education directed at the prevention of alcoholism, treatment of those currently afflicted with the illness, and continuing research into the causative factors and treatment procedures.

Enthusiastic Response

The response to our efforts in alcoholism rehabilitation has by far been more enthusiastic and spontaneous than we anticipated. In the area of education, the demands of the people upon us have exceeded our ability to serve. But because of a shortage in personnel and funds, we cannot meet the requests for literature, preventive workshops, institutes and teacher training courses. If we are going to meet, not the needs, but the demands, of the people, we must have additional financial support to be allowed to

(Continued on page 32)

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The Director explains the workings of the NCARP, its past and its future.

THE N. C. A. R. P. PROGRESS AND PROBLEMS

BY S. K. PROCTOR

EXECUTIVE DIRECTOR

THE basic principles of public health require that any attack on a health problem consist of three aspects—education, treatment, and research. This fact is no less true when we consider the public health problem of alcoholism. This does not mean that all three phases of the attack must be launched simultaneously or that they must be present in every city, town or village in a given state. It does mean that the three-pronged attack must be incorporated into a state alcoholism program, if it is to be effective.

Thanks to the wisdom of certain members of the 1949 General Assembly and of the Hospitals Board of Control, who were concerned with establishing the North Carolina Alcoholic Rehabilitation Program, the Program was set up to include the three-phased approach. Financial resources in the amount of $300,000 for the 1949-51 biennium, appropriated by the General Assembly, made it possible to take immediate steps to implement all three phases.

An in-patient treatment center was established at Butner, N. C., using some of the psychiatric staff of the State Hospital as therapists. Financial arrangements were made with community Mental Hygiene Clinics whereby they would provide out-patient services for alcoholics in return for modest subsidies from the NCARP. An education-information service was established in the early days of the Program, under the direction of a trained person. From a small sum provided for research, it was possible to commission the Institute for Research in Social Science at the University of North Carolina to undertake five basic research studies on various phases of alcohol problems.

The NCARP is unique in that it was provided enough funds at the outset to launch treatment, education and limited research activities. Had

the resources not been immediately available, the Program's development undoubtedly would have been along different lines, perhaps beginning with an educational program and moving later into treatment and research.

That, in a capsule, is the way the NCARP began. But what of the Program today? Does it still engage in education, treatment and research activities? Have these services increased? Does the Program enjoy adequate financial support? What are its special problems and needs? Education-wise the NCARP is carrying on optimum activity. This aspect of the work has shown a steady growth since its establishment. Public interest in alcohol problems, as evidenced by invitations to speak and teach, requests for literature and other services, which pour into the NCARP office, continues at a high pitch. It is impossible for us to meet completely the *demands* for our educational services, not to mention the continuing *need* for these services. Any increase in educational activity is dependent upon additional personnel and financial resources.

Large Audience

The Educational Director reports that during 1955, the latest year for which complete records have been tabulated, the NCARP conducted 187 workshops, institutes and lectures. An estimated audience of 9,000 was reached in these endeavors. This total audience included members of civic clubs, church groups, family and PTA groups and associations of professional people.

During the same period, over 130,000 pieces of literature on alcoholism were distributed upon request, 71 radio and television programs were aired, and 26 feature stories on alcoholism were released to the newspapers.

Circulation figures for INVENTORY, bi-monthly educational publication, now stand at slightly over 21,000 and voluntary written requests to be placed on the INVENTORY mailing list continue to come in at a steady rate.

Yale Scholarships

The ARP continues to make available scholarships to the Yale Summer School of Alcohol Studies. Last year, twenty-two professional people attended Yale on these scholarships. Since the scholarships were instituted, a total of 159 people representing communities all over the State have attended. These scholarships have benefited more than just the individuals selected to receive them. The physicians, ministers, social workers, educators, public health personnel and other professionals who have attended Yale are in position to use their knowledge to educate other members of their own communities and professions. Indications are that many of these people are very active in promoting and participating in alcoholism education at the local level. The State Program is currently trying to effect a closer liaison with its Yale graduates, so that the efforts of both may be coordinated. Three sectional meetings of Yale alumni were held during the past year and similar get-togethers for 1957 are in the planning stage.

North Carolina, like each of the other 47 states, has a state law which requires that scientific information about alcohol be presented in the classroom by our public school teachers. Through consultation with educators, the NCARP learned that in many communities this requirement was being ignored or, at best, inadequately met. A complex of reasons for this situation was discovered. Many teachers are not adequately informed about alcohol subjects, and

react by avoiding them altogether. Others reflect the community's ambivalence toward alcoholic beverages, and harbor strong biases toward either abstinence or social drinking, which inevitably results in ineffective teaching. Some teachers complained that there were not enough good teaching materials. Whatever the reasons, it was clear that our state's youth were not getting factual information with which to decide intelligently the alcohol question for themselves.

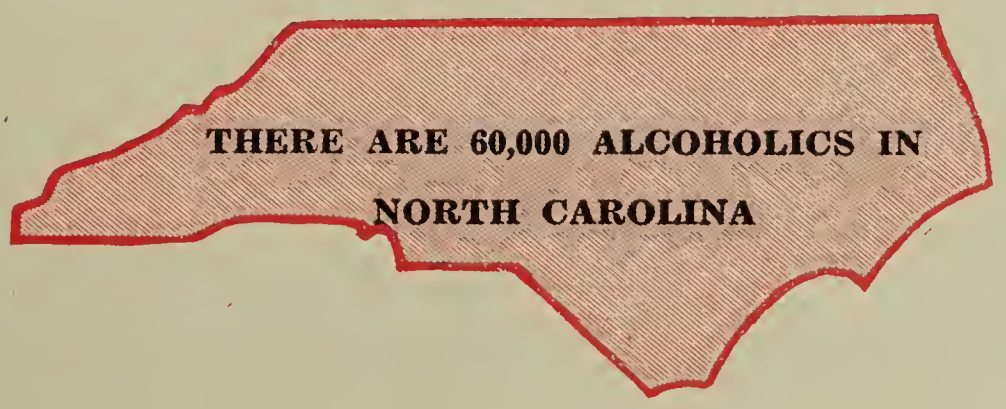
Facts About Alcohol

Recognizing that these handicaps were present, the NCARP set out to provide classroom teachers with more adequate information. At five North Carolina Colleges we have for several years sponsored and supervised the teaching of two-week courses, Facts About Alcohol, designed exclusively for classroom teachers. The participating colleges grant full college credit for the course. They have been extremely well received both by students and by the administrations of the colleges. The opportunity exists for courses of this type to be taught in other North Carolina colleges having summer school programs, but limitations in personnel and funds prevent the Program from extending itself further in this particular area. Opportunities exist for other types of teacher training courses, if the Program's resources were adequate to permit their development.

There are a number of professional groups in the State whose work duties bring them into direct contact with problems of alcoholism. Many of these professional people are able and willing to render assistance to alcoholics and their families. The trouble is, they don't know exactly *how* to help, because they have not had the chance to learn and accept the modern approach to alcoholism. Professional education, therefore, is an area in which the NCARP recognizes a great need for its services. Unfortunately, the Program has not been able to meet even a small segment of that need, nevertheless we have been active in this area.

Nurses Institutes

One of the Program's more successful efforts in the field of professional education has been the teacher-training courses already discussed. Another was our sponsorship during 1956 of two alcoholism institutes for nurses, one being held in Charlotte and the other in Raleigh. Co-sponsors with us for these institutes were the three professional nurses' organizations in the state—the State Nurses Association, the N. C. League for Nursing, and the State Board of Health. A total of 145 nurses attended, representing all sections of the state. Their reaction was so enthusiastic that similar institutes for this year are being planned.



Demand for the NCARP's treatment services has not paralleled demand for its educational services. Here, too, we have been forced to spread our resources too sparsely over the entire state. Faced in the beginning with shortages of trained clinical personnel and insufficient funds, it was necessary for the Program to turn to the Mental Hygiene Clinics to provide out-patient services for alcoholics. This arrangement was a compromise between our limitations in money and personnel, and what we recognized to be a more ideal, yet more expensive system of out-patient clinics devoted exclusively to the treatment of alcoholics. It has not resulted in the best of out-patient treatment for alcoholics and their families, nor has the service been well patronized generally. But the arrangement has not been a total loss by any means. In one of the Mental Hygiene Clinics, caseloads of alcoholics have run consistently high, and results have been gratifying. In addition, valuable experience has been gained upon which to build an improved system of out-patient clinics.

Group Psychotherapy

The NCARP Treatment Center at Butner, N. C., continues in operation, and still employs group psychotherapy as its principal treatment method. During recent months, Miss Lytle of our staff has gone to the Center weekly to conduct regular sessions of psychodrama, a relatively new type of therapy. Though it is still on an experimental basis, Miss Lytle reports some success with psychodrama, and it is likely to be continued as a supplement to group psychotherapy.

It is worth noting that since the Treatment Center opened its doors in September, 1950, a total of 2,335 alcoholics representing 417 different North Carolina towns and 94 counties have been admitted for treatment. Reports indicate that many of these former patients are maintaining sobriety and have again become stable and productive members of their communities.

Research Funds Needed

The research arm of the State Program is inactive at present. With the exception of a few basic studies done for the Program in 1950 by the Institute for Research in Social Science, no significant research on problems related to alcoholism has been promoted. The reason: funds marked for research have been penciled out of every biennial budget submitted by the NCARP since it was established. Without at least a modest appropriation for research activities, the Program will be forced to continue neglecting one of its three stated responsibilities.

Advances in treatment and prevention techniques are geared to the amount of new knowledge turned up through research efforts. Let us hope that research funds will soon be forthcoming so that the NCARP can keep pace with its responsibilities in fighting this illness, many facets of which have not seen the light of knowledge.

In summary, then, the North Carolina Alcoholic Rehabilitation Program in 1957, can point with pride at its record in some areas, and view with concern its failures in others. Education-wise, our Program is strong, though still unable to meet rising public demand for services.

In the area of treatment, the picture is spotty. The in-patient Treatment Center is adequate to meet present demand. The Center seems to be fairly well known and well accepted by all segments of the state's population. On the other hand, the Mental Hygiene Clinics have not been able

to furnish the best of out-patient treatment for alcoholism nor has the service been well patronized generally.

Research-wise, as we have stated, the Program is stalled for lack of funds.

Looking backward over the still brief seven-year history of the State Alcoholism Program, we see evidence that significant advances have been made on all fronts in bringing alcoholism to the attention of North Carolina's citizens and in taking steps to reduce its incidence. But our optimism over these accomplishments loses its rosy glow when we consider that we have just begun to scratch the surface of our growing alcoholism problem. Nearly 60,000 alcoholics from all walks of life reside within the borders of our state. There is every reason to believe that others are, unwittingly, joining this number every day. Looking at this growing group, and then looking ahead, we know that we face tasks requiring the utmost in careful planning, dedicated effort and financial resources.

Yes, there is still a vast amount of unfinished business awaiting all those who are interested in the treatment and prevention of alcoholism in North Carolina. Let's just mention a few.

First, there is the problem of how to broaden the base of our educational efforts so as to reach more professional people, while continuing and expanding educational coverage for the general public.

Next, we must provide more adequate out-patient clinic resources for alcoholics and their families, and work to have them accepted as helpful treatment places.

We must seek ways to convince those who hold the purse strings that research is vital to the progress of the NCARP and that funds for promoting research are essential.

Mental health education needs to be stressed even more so that the incidence of alcoholism in our oncoming generations can be reduced.

Teacher training programs must be expanded, so that our children can be provided with a body of objective, scientific knowledge about alcohol.

Thought must be given to the development and training of professional personnel—psychiatrists, psychologists, social workers, nurses—who are prepared to treat, and interested in helping alcoholic patients.

These are just a few of the problems that the NCARP faces in trying to carry out its responsibilities to the state's alcoholic citizens. There are many more, too numerous to mention. As we look at the size of the task, two things become obvious. First, that the Sate Program by itself will never be able to accomplish the job. Second, that if we are even to approach the ideal of our efforts—namely, rehabilitation of now-existing alcoholics and reduction in the incidence of new cases—we must look to other sources for assistance in augmenting present services and in providing other services which the State Program will never be able to provide.

THE treatment of the alcoholic requires teamwork—a close cooperation between all groups and agencies that try to help. The attitude of, "we can do it all alone," should disappear. There is no room for competition based on false pride. Such an attitude deprives the alcoholic of help he might receive.

The Treatment of the Alcoholic by Fritz Kant, M.D.

How do alcoholism programs help the alcoholic? What are the NCARP's



GOALS OF EDUCATION, TREATMENT, RESEARCH

BILL is an alcoholic. He drinks to live and lives to drink. Formerly regarded as a solid citizen, he seems to have lost all regard for his responsibilities. He has a way of turning up drunk at important times when he shouldn't be. He couldn't be found when his wife went to the hospital for their last baby, for example, and was drunk the day he was to be interviewed for a job he wanted very much. Almost constantly irritable and moody, Bill is particularly so during his frequent but short-lived sojourns "on the water wagon", which always end in another drinking bout, followed by an excruciating hangover. Since he rarely eats when he is drinking, his physical condition is deteriorating. Bill has a nice family, a wife and three children. But he largely ignores them, except when he feels they are trying to interfere with his drinking.

Bill is a sick man through and through. He is sick physically and he is sick emotionally. Inwardly he knows it but he won't admit it, even to himself. Alcoholics are usually weak characters, drifters, bums, so Bill thinks. After all, he has heard some pretty smart people say so—his minister, the county judge, among others. Bill doesn't think he is any of those things. He desperately needs understanding and help, yet in defending himself against what he feels is a "disgraceful" condition, he actually drives away the very people who want to help him.

Alcoholism programs have been set up to help alcoholics like Bill. The kind of help they offer, as in the case of our North Carolina program, will be of two different varieties. One is *direct* help, in the form of treatment

and rehabilitation services. The other is more *indirect,* in the form of public education and research. Education, treatment and research are the three means through which organized alcoholism programs can best help Bill and others like him.

Working through these three channels, how can we expect to render assistance to Bill? In other words, what are the goals of education, treatment and research in the field of alcoholism?

Aims Of Education

First, let's consider education. It may be difficult to see at first glance how an educational program can be of any help to Bill. But let us examine the aims of alcoholism education and then try to discover how they may apply to our hypothetical alcoholic.

The first important aim of education is that of furnishing drinkers and non-drinkers with factual knowledge about beverage alcohol. If Bill is typical of the majority of drinkers, alcoholics or not, he started using beverage alcohol without knowing the first thing about its physiological and psychological effects. His information consisted largely of hearsay and folklore, certainly nothing upon which to base an intelligent decision in regard to drinking. Some factual data about alcohol would have at least given him some real basis upon which to decide.

Progressive Process

Bill's uncontrolled drinking didn't develop overnight. He arrived at it through a slow but progressive process during which he displayed, one by one, telltale warning symptoms that he was headed for alcoholism. But Bill didn't recognize these symptoms in himself. He didn't know what to look for. If he had, he might have become concerned enough to seek treatment earlier, thus avoiding the full-blown illness. A second goal of education, then, is to inform users of beverage alcohol about the progressive symptoms of problem drinking and alcoholism.

A third aim of education about alcoholism is to help the public understand the alcoholic as a sick person and to recognize alcoholism as a treatable, preventable illness. Bill thinks alcoholism is a symbol of weakness and disgrace. His feelings reflect the attitudes of the majority of the members of his community. Until this attitude changes to a more constructive one, it is doubly hard for Bill to admit he is sick. Bill needs to feel that he has a bona fide illness and that others accept it as such. Good alcoholism education should strive to promote this attitude.

Treatment Facilities

Suppose Bill does decide to seek treatment. Where does he go to find it? Are there any treatment facilities near him? These and other questions will immediately pop into his mind. Education has a job to do here as well. Alcoholism education should acquaint the public with existing treatment facilities, and try to stimulate development of additional treatment establishments where there is a need for them.

Professional Education

A large part of our educational message should be directed to the lay public. But we cannot forget the professional people—physicians, psychologists, social workers, ministers and others—who are in position to render assistance to Bill. Professional people need to become better informed about alcoholism too, so that they may be understanding and effective in meeting Bill's needs. Another important aim of education, then, should be to aid those professionally concerned

with the alcoholic, so that they will be better prepared to serve him.

One of the vital areas of concern to educators in this field is that of prevention. Insofar as possible, we wish to prevent others from developing the illness from which Bill suffers. Preventive education, though it won't help Bill now, can be expected to reduce the incidence of alcoholism in oncoming generations. Alcoholism has been found to be a symptom of faulty mental health, having its roots in early childhood development. Preventive education should seek to stimulate public interest in improved mental health and in specific practices for achieving higher levels of mental health, particularly in the area of parent-child relationships.

Beyond Sobriety

Now let us go a step further. We shall assume that some of our educational effort has reached Bill and others close to him. With a new understanding of his illness and a changed attitude on the part of his family and friends, he may decide to enter treatment. What should we expect treatment to accomplish for Bill? Most people would say that treatment should get Bill sober. And we agree. But is sobriety the only aim of treatment? Let's see.

If Bill's treatment is successful, we would certainly expect that he remain sober. But we would look for more than sobriety. We would want to know if he is reasonably happy and contented, relatively free of the tensions and stresses which previously triggered his excessive drinking. Where drinking formerly occupied much of his time and effort, we would expect our recovered patient to gain satisfaction in a better balanced life of work, community and family activities.

We should not expect too much of treatment for alcoholism. For example, we can't expect it to transform Bill into a go-getting sales executive if he is just a low-pressure salesman at heart. Neither should we set our treatment sights too low. We wouldn't want Bill to be content with being just a sober but colorless, ambitionless individual when we know he has much greater potential than that.

Treatment Goals

Alcoholism treatment goals must be broad enough to allow for individual differences in capacities, intelligence and inner resources for adjustment. In our view, the goals of treatment are these: (1) to help the patient live *comfortably* without the use of beverage alcohol; and (2) to help him function adequately within the limits of his capacities.

Whether treatment and education accomplish the goals we have set depends in large measure on the presence of a coordinated program of re-



search. We cannot hope to treat alcoholics like Bill with any degree of success or eventually control the illness if our techniques are based on unproved opinions or armchair philosophizing. Treatment procedures and preventive education must be grounded in verified factual knowledge. Supplying this knowledge is the task of research.

To much of the public, scientific method as employed in research still looks like so much hocus-pocus, indulged in by ivory-towered eccentrics clad in white coats, working amidst beakers, test tubes and microscopes. It seems to have little relevance to problems of human behavior, such as mental illness, delinquency or alcoholism. This is a misconception. As a matter of fact, scientific research is quite practical. And it isn't confined to things that can be studied only in a test tube or under a microscope. Here is how it works.

Scientists advance certain hypotheses, which are really informed "hunches" that certain things *may* be true. Then they attempt to test these hypotheses in accordance with recognized principles of scientific methodology. Reports on the researchers' findings are then published in professional journals where they are subjected to the critical examination of their colleagues. Other researchers may test the hypotheses further, either confirming them or presenting negative findings. Some of these "hunches" are eventually accepted as true and are used in practical application. Others are discredited and discarded.

The goal of any research based on the method outlined is verified factual knowledge. When the method has been applied to the field of alcoholism, useful new insights into the causes, treatment and prevention of the illness have resulted. But considering the quantity of study which has been concentrated on other health problems, alcoholism has had pitifully little. There are still wide gaps in our knowledge. They must be closed. Research is the answer.

Education, treatment, research—there you have the three essential functions of an alcoholism program. Each one is important in itself, yet each is dependent on the other for its full effectiveness. Their combined goals are recovery for Bill and others now suffering from alcoholism, and reduction in incidence of the illness in future generations.

BOOK KITS FOR TEACHERS

The ARP Book Kits, containing reference material on alcohol and alcoholism for use in the classrooms, have been very popular and widely circulated among high school teachers throughout the state. In order to make the material more useful for the teacher in conducting alcohol education, the ARP Book Kit has been revised. The revised contents contain the following material: "Alcohol and Human Affairs" by Spalding and Montague; "Alcohol Education" by Hirsch; "The Problem Drinker" by Hirsch; "Alcohol, Culture and Society" by Patrick; "Alcohol and Social Responsibilities" by McCarthy and Douglass; "Teen-agers and Alcohol" by McCarthy and "Manual of Reference for Alcohol Education" by the Division of Alcohol Education, Department of Education, Victoria, British Columbia, Canada. Teachers desiring a kit may write the Education Director, 15 West Jones Street, Raleigh. Each kit is loaned for a one-month period at no charge.

NORTH CAROLINA'S FIGHT

The NCARP will continue to lead the attack, but it cannot lick the growing problem alone. Here is a call to the State's communities to join in an all-out effort to control this costly illness.

I. A NEW APPROACH

Today, the North Carolina Alcoholic Rehabilitation Program stands at a crucial point in its development.

The facts which brought it to this point are these. The number of alcoholics in the state is on the rise. The total now stands at an estimated 60,000 alcoholics as compared with less than 50,000 in 1949. While the increase is directly linked with recent growth in the state's population, it is still a startling fact. It is imperative for the well being of the state that this trend toward an ever-increasing alcoholic population be reversed. To do this calls for stepped up efforts in education, treatment and research. But even now, the NCARP's staff and budget are pushed to the limit in attempting to meet even a portion of existing needs. The opportunities for extending needed services by the State Program are innumerable. But funds and personnel to do the job are not immediately in sight.

What should be done to meet this situation? Should the State Program go on trying to spread its present resources thinly over the entire state, hitting the high spots, but unable to do a thoroughly effective job in any one area? Or should it press to expand its financial support and personnel roster to the point that it can anticipate and meet *all* the needs of the state's population?

Neither Alternative

The answer does not seem to lie in either of these two alternatives. The first would result in sub-standard services in some cases, and in neglect of some of the most pressing needs. The second alternative would be well-nigh impossible to accomplish. While there is certainly a necessity for some increase in funds and personnel by the State Program, it is too much to expect that even a greatly expanded State Program could effectively meet *all* the state's needs for rehabilitation and prevention services.

May we suggest that this is a time for some new thinking regarding the role of the NCARP in the fight

(Continued on page 16)

AGAINST ALCOHOLISM



against alcoholism. It is time to take a close look at the Program's existing resources—funds and staff—to see how they may be better employed and where additions should be made. It is time, too, that we recognize our limitations in trying to serve a sprawling state from Manteo to Murphy. The point has been reached when the NCARP must look to sources outside itself for help in sharing the responsibilities of alcoholism treatment, education and research.

Community Help

Where can we expect to find the help that is needed? We believe that the place to find it is in the local communities of the state. There is evidence that many North Carolina communities are deeply concerned about alcohol problems and interested in extending education and rehabilitation services at the local level. This interest and concern should be channeled through organized local action groups, whose aim would be to make the wanted services a reality.

Several communities in the State have already joined the fight against alcoholism. Working through citizens' committees, they first studied the problem, then set up their own local alcoholism programs. The State Program hopes and believes that many more such community programs will be developed in the near future. We believe that they are the state's best hope for trimming our snowballing alcoholism problem down to size.

It is not unreasonable to expect cities, counties and towns to help the state-supported program bear the load. Joe Alky is a citizen of his county and town as well as of the state. His community shares the benefits of his rehabilitation to responsible citizenship. Likewise, the community shares with the state the benefits of a lowered alcoholism rate which preventive education promotes.

We are not suggesting that local alcoholism programs will ever displace the NCARP. The anticipated local developments need and deserve to have the assistance that a strong State Program can offer in direction and leadership. There will remain certain areas of service that can be more efficiently provided at the state level than by local programs. On the other hand, there are many activities currently engaged in by the NCARP which could be more effectively handled at the local level. In the event that a network of local alcoholism programs develops, it would be vitally important that lines of responsibility be clearly drawn so that their efforts and those of the State Program would be integrated into a statewide plan. Otherwise we would have a hopeless hodge-podge of organizations, duplication of services, and more confusion than progress.

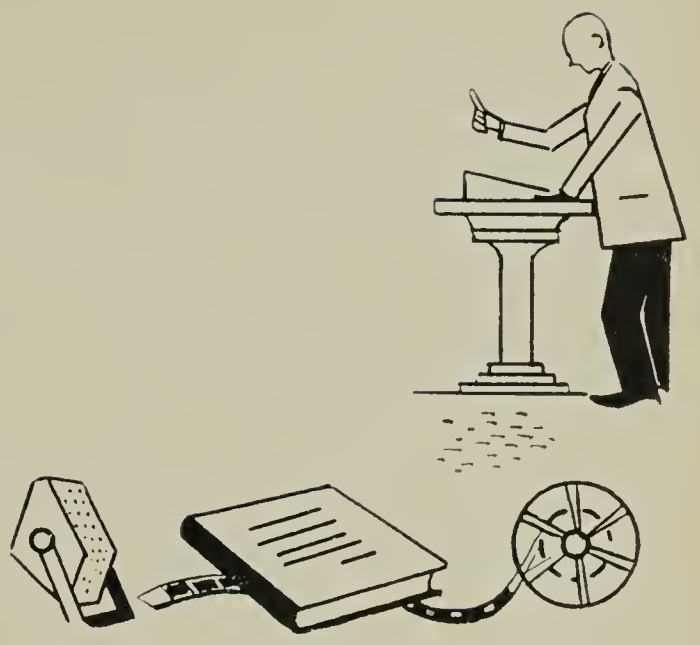
Cooperation Needed

The needs of the state for education, treatment and research in the field of alcoholism problems are formidable and growing every day. We must recognize that no state-level alcoholism program alone can do the job required. Neither can any local community alcoholism program do an effective job unassisted. But cooperatively, we can plan and work toward meeting the challenge.

It is our purpose in the following three articles to explain how our hopes for the future might be implemented in the areas of education, treatment and research.

Some people have a veneer that comes off easily with a little alcohol.
—Paul Harrison in N. Y. World Telegram

How can the NCARP and the local communities help each other in the important work of . . .



II. EDUCATION

WE shall assume that in the next few years a number of local alcoholism programs will develop over the state. Given that situation, how would the responsibilities and duties be divided between the local program and the State Program? What specific services would the local programs be in a better position to provide? What services should the State Program be expected to provide? How would the State Program assist the local programs?

First, let's consider the role of the State Program in the area of alcohol and alcoholism education. The education division of a state alcoholism program would have the following responsibilities:

1. The State Program would continue to *promote and direct college courses of instruction in facts about alcohol and alcoholism.* With a larger NCARP educational staff, the courses could be expanded to include more summer sessions for teachers, courses in the regular curricula of our colleges, and extension-type courses of instruction.

2. Our State Program would *study, screen, select and publish literature on all phases of alcohol subjects.* Trained educators at the state level would study all the current literature published in the field, examining it for accuracy and objectivity. The best of this material could then be recommended to local information centers and alcoholism programs for their use. Trained journalists at the state level would re-write the more technical material, publishing it in pamphlet or reprint form, or in the NCARP's own educational journal. In this way a continuous flow of good printed material would be available to local programs and to the people of the state at low cost. This is a service that the State Program, with its staff of specialists, could provide much more efficiently and economically than any one local information center, with its small staff and limited funds.

3. The NCARP could *maintain a first-rate reference library, made up of all the known and available works an alcohol and alcoholism.* Researchers, students and interested laymen wishing to dig deeper into the problem would have a ready source of information close at hand within their own state borders. At present, a researcher has to travel long dis-

tances to gain access to the basic resource material in the field.

4. The staff of the State Program could *select and produce radio and television programs, exhibits, displays and posters for use over the state.* Distribution and placement of these materials could be handled much more effectively by local alcoholism programs and citizens committees, since they would be in touch with local needs. But local programs would have neither the time, funds, nor trained people to devote to producing these educational tools. Here, then, is another area in which the State Program could assist local communities in developing a more complete program of education.

5. *Scholarship aid to professional people to attend the Yale Summer School of Alcohol Studies* should continue a part of the NCARP's educational work. More attention should be given to geographical distribution of scholarship recipients, as well as to their professional qualifications and community status. Local alcoholism programs might also offer one or two Yale scholarships, provided their funds would allow it. If not, they could help the State Program in selecting scholarship recipients by recommending qualified local people.

6. *The Program should build and maintain a state-wide volunteer Speakers and Teachers Bureau,* comprised of persons with adequate training and experience to speak authoritatively on alcohol problems. State and local programs should constantly seek to develop new resource people qualified to speak and teach. An up-to-date list of Bureau members would be made available to all local committees and information centers for their use in filling requests for speakers. As new resource people were developed at the local level, they would become members of the local program's "Speakers and Teachers Bureau", and their names would be added to the state list as well. Under this set-up, qualified people could be located quickly and speaking and teaching engagements scheduled with a minimum of effort.

7. More effort could be devoted to the *promotion and direction of special seminars, institutes and conferences on alcohol problems for professional persons and professional groups.* For example, the State Program might sponsor an institute for school supervisors to consider latest methods and materials for teaching alcohol facts in the public schools. Public welfare casework supervisors might be brought together to consider ways of helping their caseworkers deepen their understanding of alcoholism. The opportunities for the State Program to provide these and similar services are almost limitless. But the State Program cannot meet all the needs. Many local teacher groups,

INFORMATION BEFORE REHABILITATION

THERE is need for more public information about the problem of alcoholism. The alcoholic, to be helped, must present himself for treatment. But before this will happen, he must understand that he is in need of treatment, just as is the man or woman suffering from diabetes, tuberculosis, cancer, or heart disease. Public opinion must help to get tax-supported treatment facilities for alcoholism, just as it does for other public health disorders.

—From "Facts About Alcohol" by Raymond McCarthy

medical societies, nursing organizations, and other groups would perhaps never be reached from the state level. Here, local programs could be expected to do some effective work. But again, the State Alcoholism Program would be in position to offer some direction and experience in developing this local service.

That's the way the educational division of our State Program might look. Now, what about the local program? Where does it fit into the picture?

Treating Alcoholics

The local alcoholism program, with its focus in an information center and staffed by a full-time or part-time Executive Secretary, can carry on many valuable functions in the fight against alcoholism. One of the most valuable educational functions the local alcoholism program could carry out would be to help obtain needed hospital facilities for the acutely-ill alcoholic. These facilities are still denied the alcoholic in many cities and areas of our state. They are not available because those concerned with local hospitalization generally do not understand alcoholism and the alcoholic. Alcoholism is not yet accepted by these individuals as an illness. The hospital administrator, the physician and the nurse all need to have brought to them a greater understanding of the alcoholic as a sick person. When this is accomplished, hospital doors will open to alcoholics. It can be accomplished only by education and at the local community level.

The local alcoholism program could inquire into the extent of alcohol education in the local public schools. North Carolina has a law which requires that alcohol and alcoholism education be presented in our public schools. In some areas of the state the provisions of the law are being carried out quite adequately. In other areas of the state, however, the law is being overlooked. The local program could find out, in a tactful way, of course, whether the young people in their community are receiving the alcohol and alcoholism education they should have. Each and every young person in the community should be equipped with adequate knowledge to make a rational decision on whether or not they will use beverage alcohol. Education in our schools on alcohol subjects can help provide the facts and understanding by which each young person can make his decision.

After canvassing the situation in the schools, the local alcoholism program may find that it can be of assistance in helping teachers carry out alcohol education. It may, for example, provide good materials for the schools. It may purchase and place in the schools films on alcohol and alcoholism film strips, books, pamphlets and other aids. Many of these materials could be furnished through the State Program's educational division, previously described.

Aid To Teachers

The local program may assist in still other ways with education in our schools. Undoubtedly, one of the reasons that teachers have shied away from instruction in alcohol and alcoholism is that they have not been adequately prepared to teach the subject. Until the last few years, our colleges have done little to prepare the teacher to carry on this subject in elementary and secondary classrooms. Now this has changed. For the past several years, we have had summer schools in five of our teacher-training colleges. These summer courses are brief but intensive and concentrated orientations to alcohol problems. They are designed specifically for teachers and are an attempt by the NCARP and the co-sponsoring

colleges to provide the teacher with an adequate background in alcohol problems. The local alcoholism program sould seek to stimulate local teacher interest in attending one of these summer courses. If the program's budget were adequate, it could even provide several summer school scholarships for interested teachers in the community.

The establishment of scholarships in the Yale Summer School of Alcohol Studies for educational supervisory personnel and other professional people is yet another endeavor that the local alcoholism program could carry out, provided financial resources are available. The course at Yale is longer and more comprehensive than the courses given in the North Carolina colleges. It is, therefore, better suited to the needs of school superintendents, principals, and supervisors of instruction—those who are responsible for initiating courses on alcohol problems in the public schools and who supervise the work of many classroom teachers in this part of the curriculum.

Professional Scholarships

The Yale Summer School can be of great value to other professional people also. This includes ministers, physicians, psychiatric social workers, caseworkers, psychologists, and others. Any members of the several professions who come into direct contact with the alcoholic problem should be considered as prospective recipients for Yale scholarships offered by the local program.

Churches are increasingly becoming interested in alcohol education. Many of the larger denominations are developing comprehensive programs in this area. Those responsible for these programs are frequently interested in obtaining information concerning visual aids and literature. The local alcoholism program is in a position to help meet these needs. It should stimulate the church's interest in any way it possibly can, and aid it with materials and speakers. Here again, literature and visual aids recommended or prepared by the State Alcoholism Program can be used to great advantage by the local program.

Education For All

The local program might also stimulate church interest in other areas closely allied to alcohol problems. For example, it might stress the need to church people for premarital and postmarital counseling services. It might suggest that the church is in a wonderful position to carry on a program of mental health education and parent-child education.

The local program might carry on comprehensive education with specific professional groups in the community. For example, seminars on alcoholism and related alcohol problems could be set up for ministers. Actual case history material might be utilized in these seminars to help ministers understand their role in the treatment of the alcoholic—how they may counsel with him, and how they may help the family of the alcoholic.

Specific educational projects could be designed for industrial and police groups. In-plant education for foremen and supervisors could very profitably be organized. More and more American industry is coming to realize the financial bill it is paying because of problem drinking. It is, therefore, beginning to welcome suggestions on how it may reduce alcohol problems among employees.

Each year in North Carolina a number of deaths occur in our jails because incarcerated alcoholics are not given needed medical care. Law enforcement officers must be helped in coming to an understanding of alcoholism as an illness and the neces-

sity of providing adequate medical check for each arrested inebriate.

Another facility the local alcoholism program can cooperate with in its educational work is the community's public library. Librarians tell us that literature on alcoholism is in great demand. The local program can help provide this by placing books, pamphlets and reference materials in the library. It can also devise and place at the disposal of the library displays and exhibits on alcoholism. It may secure and place in the library the comprehensive display disseminated by the State Library Commission, Raleigh.

Displays and exhibits may be placed at agricultural and health fairs throughout the area. They may be used also in government buildings, department stores, and other exhibition centers.

The local program would, of course, make constant use of all the usual media of public education: the press, radio, television, and speakers bureau.

FOR CLERGYMEN

A NEW PUBLICATION OF THE N. C. A. R. P.

FREE FOR THE ASKING

ALCOHOLICS ARE GOD'S CHILDREN, TOO, a new clergymen's guide on alcoholism has been distributed to more than 2,000 North Carolina clergymen and is now available free on request to the NCARP. The 50-page pocket size booklet has been published in response to requests from clergymen for practical information to aid them in dealing more effectively with alcoholics and their families. The co-authors are clergymen and religious educators with specialized knowledge and experience in the field of alcohol problems. Subject matter in the booklet includes: The Church and Alcohol Problems; The Response of Religion to Alcoholism; How the Minister May Help An Alcoholic; Pastoral Counseling and the Family of the Alcoholic; and Work With Youth in Relation To Alcohol.

WRITE OR SEND THIS COUPON TODAY FOR YOUR COPY

N. C. ALCOHOLIC REHABILITATION PROGRAM

15 WEST JONES ST., RALEIGH, N. C.

☐ Please send me a copy of ALCOHOLICS ARE GOD'S CHILDREN, TOO

☐ Please place my name on the mailing list for INVENTORY magazine

Minister's Name _____

Street Address _____

City & State _____

What kind of treatment facilities are best suited to the individual needs of alcoholics?



III. TREATMENT

OUR proposals for improved alcoholism services in North Carolina would be incomplete without some consideration of treatment. What sort of treatment services can we envision that would come closer to meeting the total needs of the alcoholic than the ones we are now able to provide?

Treatment of alcoholics, whether in-patient or out-patient, is based on the philosophy that alcoholism is an illness involving the total person—his physical being and his personality. This means that treatment for the alcoholic must include medical attention for his physical problem, therapy for his emotional and psychological difficulties, and counseling for his social and environmental problem.

The question is, how do we embody all of these factors in a treatment program? Here is a plan which we think might accomplish these objectives:

A system of regional out-patient clinics devoted exclusively to the problem of alcoholism should be considered. The clinics would be located so that persons in every geographical area of the state would have reasonable access to a treatment facility.

Each alcoholism clinic would be situated near a general hospital willing to accept an alcoholic patient needing treatment for an acute condition. Oftentimes an alcoholic coming to the clinic, needs immediate medical treatment before any attention can be given to his underlying emotional problems. Local physicians and the nearby hospital could answer this need.

The method of helping the alcoholic which has proved to be most successful is known as the "team approach." In the team approach, the disciplines of medicine, psychiatry, social work, and psychology unite their efforts in behalf of the patient's recovery. The clinics that we envision would be based on this approach. The minimum clinical team required would consist of the following professional workers: a psychiatrist, a psychiatric social worker, and a psychologist. It would also be ad-

vantageous for the clinic to retain the part-time services of a specialist in internal medicine or general practitioner, if possible.

How would each of these professional people function within the clinic? First, let's take a brief look at the psychiatrist. He would be responsible for the psychiatric diagnosis of each alcoholic patient entering treatment. If psychotherapy is indicated for the patient, that would be the psychiatrist's realm. In addition, he would supervise all other treatment going on in the clinic, would be available for staff consultation, direct all staff conferences, and would take the lead in formulating clinic policies.

Patient Therapy

The psychiatric social worker, too, would have a number of important roles. First, she would be responsible for admission procedures. She would talk to the newly-arrived patient, explain clinic procedures, discuss treatment fees, and would pave the way for the patient's entry into the therapy. Other duties of the psychiatric social worker would include casework service with patients and their families, continuing therapy under supervision of the psychiatrist, and participation in setting clinic policies.

The psychologist would use his skills in administering to each patient a battery of selected tests. His report of test results would assist the other members of the team in diagnosing and treating the patient's condition.

If a part-time internist or general practitioner were employed by the clinic, he would be expected to do a complete physical examination and diagnosis on each new patient. If a patient needed hospitalization, the physician would arrange his admission to the nearby hospital. A patient whose withdrawal symptoms were not serious enough to require hospitalization but was obviously in need of some medical attention would be seen by the doctor and administered palliative medication to relieve these symptoms.

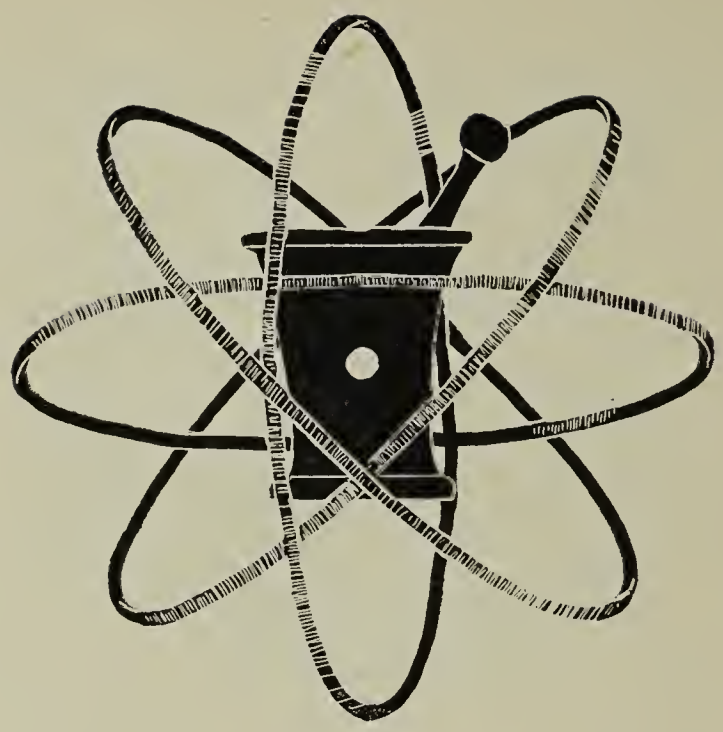
An alcoholism clinic with the professional staff described would be designed to meet the needs of the individual alcoholic, no matter what they happened to be. His physical needs would be looked after. His emotional problems would be aired. And the more practical problems of home, job and family would get consideration.

Given this out-patient setup, there might appear to be no necessity for having an in-patient treatment center. But that is not the case. There would still be a need for an in-patient unit, though its role might be somewhat altered.

In selected cases, a patient's condition might require more intensive treatment than would be available in the out-patient clinic. In other cases, temporary separation from the problems of the home and community environment might be essential to the patient's recovery. These are patients who would be referred to the in-patient treatment center where they would receive a more concentrated course of therapy. After having obtained the benefit of hospitalization at the center, the patient would, upon his discharge, be referred to the out-patient clinic nearest him for continued long-term therapy.

Locate one of these clinics in, say, five key areas of the state and our plan for out-patient services would be complete. If such a plan were carried out, greater numbers of alcoholics might be attracted to seek treatment. And more importantly, the quality of service offered by these "alcoholic-centered" clinics would motivate patients to continue in treatment long enough to get maximum help.

The NCARP should be active in the field of research. Here is how a start could be made.



IV. RESEARCH

THE needs for research in the field of alcoholism are innumerable. The facts we know about the illness are far outweighed by those we don't know and would like to know. Just for a start, we could suggest the following:

What do doctors know about this illness? What would they like to know? What do they need to know? How successful are our present treatment methods in terms of recovery? How could they be changed to be more effective? What is the relationship between alcoholism and family dependency, juvenile delinquency, crime, other diseases? What is the relationship between alcoholism and industrial accidents, absenteeism, loss of wages? How can industry and labor benefit from a new understanding and a new approach to the problem of alcoholism? What are the factors that contribute toward the development of alcoholism? How might they be better controlled? What are the best treatment techniques for controlling alcoholism and how might they be more widely applied?

The list of unknowns is endless, and no one is more aware of the many unanswered questions than members of the NCARP staff. We would like someday to be able to support large-scale research which would explore some of these unknown areas and throw new light on many of the problems. But we must be realistic. Such a research program is not immediately possible. Nevertheless, a start toward developing a research program within the NCARP must be made. Given a minimal increase in budget to pay the salaries of two additional personnel, a start could be made now.

Research Director

We would like to see a position as Research Director set up in our State Program. The position would be filled by a person with graduate training in the social sciences and with experience in research methodology. The Research Director would require the services of a statistical clerk to assist in the routine matters of organizing and systematizing records. With the addition of these two positions, a limited research program could be launched.

The Research Director would first turn his attention to the State Program itself. It would be his task to

give some shape and direction to the whole system of record keeping now employed in all the Program's activities. Voluminous records exist at the NCARP Treatment Center, in the outpatient clinics, and in the educational section. But they must be organized into some intelligible and uniform system and reduced to some common denominators if they are to be put to profitable use. Once the system is established, the treatment and educational staffs should be instructed in its use so that all future record keeping would be standarized.

Records Are Valuable

When the records have been classified, they will provide a wealth of information for studying and evaluating Program procedures and progress. The Research Director, with his objective view of the whole Program, could spot places where mistakes have been made, and areas where our efforts could be redirected along more profitable channels. Standardized record procedures would enable us not only to evaluate the Program's past performance, but to do periodic evaluations of present and future activities as well.

There are many resources and agencies outside the State Program which are in contact with the problem of alcoholism. City and county courts and jails, welfare departments, health departments, physicians and hospitals,—all see different sides of the total problem. We in the State Program would like to know more about these resources, their attitudes and their methods. Here is the second area of study that should be undertaken by a research person at the state level.

We would like to know more about methods of handling alcoholics in city and county jails. Do they provide any kind of medical attention for alcoholic prisoners? Have jail personnel been trained to recognize the difference between intoxication and other illnesses with similar symptoms?

What Are The Answers?

What are the attitudes of welfare caseworkers and public health workers toward the alcoholic? How do physicians and hospitals in the state feel about the alcoholic? Are they willing to accept him as a bona fide patient who needs treatment?

What about chronic drunkenness offenders in the courts? How serious is that problem? Are adequate court records kept on recidivists? If not, how could we assist the judges and clerks in setting up more complete records?

Using scientifically oriented survey methods, the Research Director could get the answers to these questions. And the resulting body of information would have a very practical use. For example, if a survey revealed that the majority of law enforcement officers had little understanding of alcoholism as an illness, the NCARP would beam more of its educational effort toward the law enforcement group, in an effort to change their attitudes. The same would be true with any other groups found deficient in understanding.

Key Role

In addition, the Research Director should survey research facilities and research personnel already existing in the universities and health centers of the state. We know that there are a number of these resources. Perhaps some of them could be interested in doing alcoholism research. The NCARP Research Director should try to stimulate this interest. He might do this by meeting with research people in the universities and clinics and pointing out to them the problem areas, the sources of scientific

materials, and even offering to assist in designing research problems.

We hope that in the future, money will be made available so that the NCARP can make grants for long-range research. When that day comes, the Research Director will have a key role. He would study and screen research proposals, and recommend promising projects deserving financial support. It would be his responsibility to help develop research designs consistent with good scientific methodology. In addition, he would keep tabs on other sources of research money, outside the State Program. Promising research projects which the State Program did not have funds to support could be referred, for example, to the U. S. Public Health Service for consideration.

Until the NCARP is able to engage in a full-scale research program, there are still many potentially fruitful projects that a trained Research Director could begin at once. This would not require the expenditure of large sums of money, only enough to pay the director's salary and that of a statistical clerk. We do not think this is an unreasonable proposal. Out of it would come much valuable information upon which to build a more efficient and effective State Alcoholism Program.

IN addition to treating the alcohol problem, work should be done to aid in preventing the alcohol problem from developing through helping to remove the anxiety of an individual and/or helping him actually to understand himself in this culture through psychiatric study and therapy, distributive or deeper analysis, and cooperation with those interested in mental hygiene who will follow through on a practical basis.

Robert W. Seliger, M. D. in
A Guide on Alcoholism for Social Workers

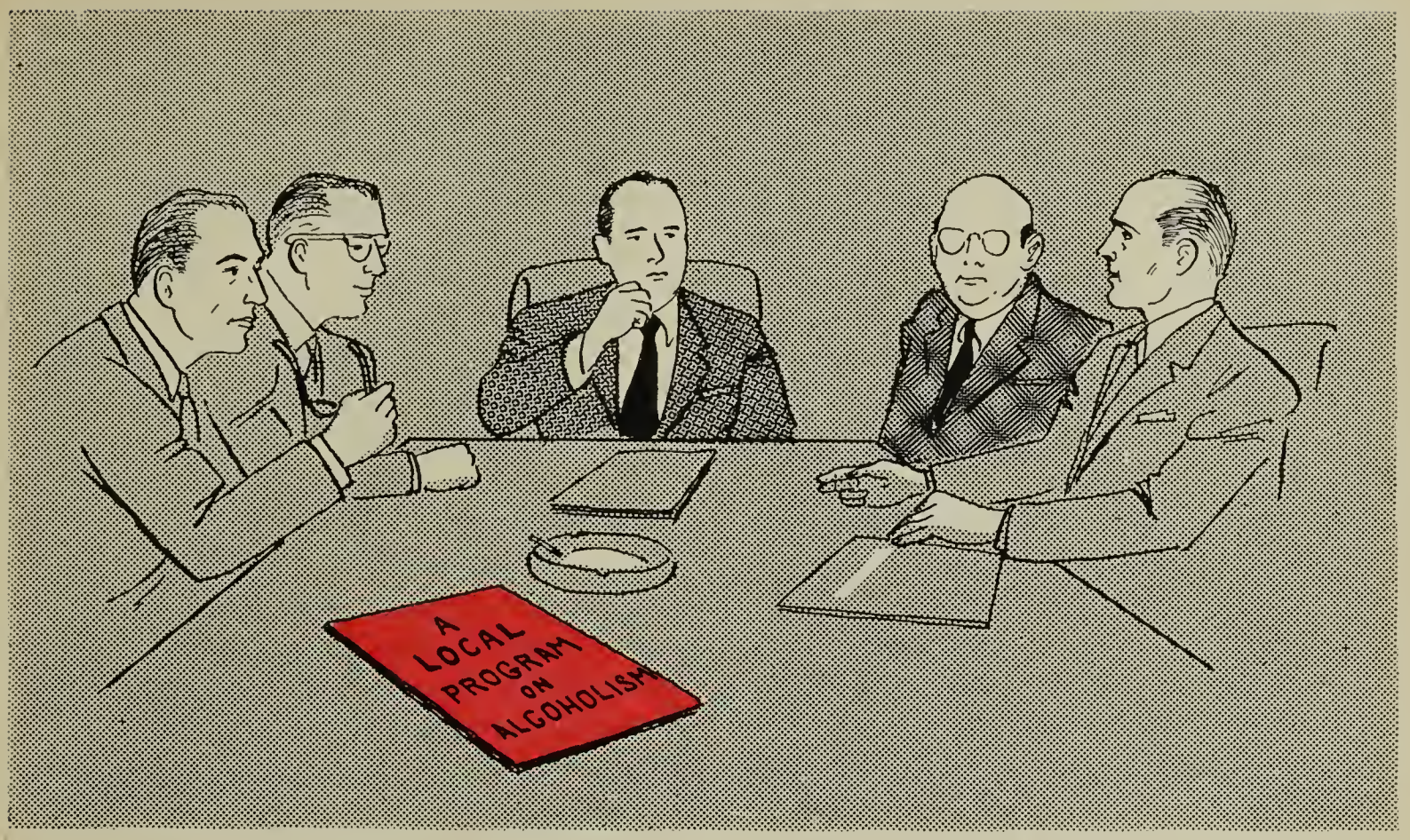
ALCOHOLISM affects the physical, emotional and social life of the individual. So the treatment for it must cover all of these areas. Correcting the physical effects of the last drinking spree will make the drinker feel better, but it won't get at the root of his problem. Getting him to change jobs, to move to another neighborhood, or putting him in jail will at best only interrupt his drinking. There will still be the basic problem of how he feels about himself.

At many clinics and hospitals, the alcoholic is given double-barreled aid: help with the body disorders that alcoholism causes and help with his emotional and social problems.

—From "Facts About Alcohol" by Raymond McCarthy

YOU can't cure alcoholism with logic. The alcoholic uses his feelings when he decides to drink, not his mind. In order for him to recover, a readjustment of those feelings is necessary so that he can face the world comfortably and confidently without alcohol.

—From "Facts About Alcohol" by Raymond McCarthy



One Community's Answer

BY CLAIRE CHENEY

ASS'T EDITOR

They learned that the alcoholic's problem was their problem too.

(Editor's Note: This article was written to convey to the reader the way in which members of a community can work together to form a local program on alcoholism. Grayson is a fictitious town in North Carolina as are the people therein.)

ONE night in the small town of Grayson, North Carolina, fifteen people met at the home of Tom Palmer, a local businessman. This was not a social visit. Tom, who was president of Grayson's leading civic group, had called these people together to discuss a situation which he felt needed attention. The problem was alcoholism.

Present at the meeting were the Chief of Police, a local minister, a county physician, the president of the PTA and several other members of the community. All represented varied vocations and interests, but with one thing in common—a concern over the increasing rate of alcoholism in their county.

Ed Harris, the Chief of Police, read a report on the number of drunkenness arrests during the past year. Many of those arrested were known alcoholics who were as used to the jail cells as their own bedrooms. Reverend Lawrence told of his concern over the young people. He knew

of several teen-agers in Grayson who were drinking excessively.

Dr. Thomas spoke to the group about the need for proper medical and psychiatric care for the alcoholic. He reminded that the alcoholic was a sick person who needed society to help him.

This led everyone into a discussion of what they, as private citizens, could do to provide their county with adequate knowledge of alcoholism and alcohol. They agreed that an educational program, if one were to be set up, should cover the following elements. (1) Facts about alcohol in regard to its effects on the human mind and body, (2) Facts about alcoholism and (3) Prevention of alcoholism.

Funds Are Discussed

The meeting led far into the night, each person contributing his ideas on the value of an educational program on alcoholism. Where would funds come from to support such a program? Who would head the program and would Grayson give its wholehearted interest to it?

Tom Palmer thought perhaps he could suggest a source of funds for the program. He knew of counties who received support from ABC revenue, and others who were supported by the United Fund and the County General Fund. Perhaps Grayson County could receive support from such sources.

Program Gets Under Way

When the group broke up, they agreed to spend the next weeks doing careful study on alcoholism. Sarah Adams, president of the PTA, was elected head of the committee to study Alcoholism Programs in other counties. With the help of the State Alcoholism Program, she could get much needed information about starting a local program of their own.

The weeks flew and with them, hard work, discouragement, until finally the Grayson County Program on Alcoholism was formed.

How can a small nucleus of people such as those who met that night at Tom Palmer's grow to form a full-fledged program on alcoholism and how can other North Carolina counties and towns benefit from their example? To answer that question, we need to go back to our group's second meeting.

Tom Palmer arrived at Town Hall that night carrying under his arm a complete set of figures specifying the amount of money necessary to operate a program on alcoholism and a breakdown of specific expenses. He had been to the county ABC Board and found them eager to give financial support to an educational program. The money was to be turned over annually to the County Commissioners who, in turn, would allocate funds to the program as needed.

What About Treatment?

The next question was that of treatment for the alcoholic. Grayson County could not afford a treatment center for alcoholics, but if they could persuade the local hospital to treat cases of acute alcoholism, that, together with the Alcoholism Clinic in the next county which was available to those who wanted psychiatric consultations and follow-up treatment, would provide adequate treatment for the alcoholic. Of course, the big question was whether the hospital would agree to open their doors to the alcoholic.

Sarah Adams then made her report to the group. In her study of Grayson's needs and facilities and through talking with various agencies in the county, she had found enthusiastic response in most areas. The Public Health Department was anxious to cooperate in any way possible, as was

the local AA chapter, the PTA and the women's clubs.

With this good news, the group settled down to planning the actual groundwork of the program. A committee was appointed to meet with the Hospital Board of Directors and the administrator to propose their plan for alcoholism treatment.

Controversy Arises

At first, the committee was met with opposition. The hospital didn't want their wards to be used for "sobering up" purposes for every drunk in town. They complained that the same alcoholics would appear for treatment over and over again. They said if they treated one alcoholic, they'd have to treat all. They didn't have the time or the facilities to "turn their hospital over to drunks."

The committee assured them that if they treated only acute cases of alcoholism, those cases which needed immediate medical attention, their hospital would not be used for the reasons they feared. They explained their program to them, and stressed the importance of the hospital's participation in alcoholism treatment—that without their help, the program would fail.

The hospital agreed to admit only acute cases of alcoholism. They told the committee that under no circumstances were their facilities to be used only for comfortable "sobering up", but they could see the need for medical care for the acute cases. Another battle was won.

Through the recommendation of the School of Public Health in Chapel Hill, Stuart Anderson, a health educator with an excellent background in the study of alcoholism, was hired as administrator of the Grayson County Program on Alcoholism.

An Advisory Board was selected from leading citizens of the county to work with the health educator in setting the policies of the program. Members of the Board included Tom Palmer, Dr. Thomas and Reverend Lawrence.

To house the Information Center, as they named their headquarters, they rented an office in downtown Grayson. From the Center all policies of the Program were coordinated and set into action. It was here that the people of Grayson County had available to them any desired information on alcoholism.

Widespread publicity was given the Program by local radio stations and

ONE ILLNESS, MANY EFFECTS

ALCOHOLISM is a threat to the individual and to his family, friends, and employer. The alcoholic is exposed to accidents and injuries while he's drinking. He's likely to contract diseases because he neglects good habits of hygiene. Alcoholism causes financial waste. The alcoholic may lose his job. He also upsets his family's life and provides a bad environment for his children.

Alcoholism is also a burden to the community. Estimates are that 50 to 60 per cent of the people in local jails are sentenced for drunkenness. When the alcoholic can't support his family, welfare agencies are often called on to help. Hospitals also must take care of alcoholics who have had accidents and are unable to pay for any treatment. So it's a public problem as well as an individual one.

—From "Facts About Alcohol" by Raymond McCarthy

by the newspapers and through the cooperation of the members of the community, it wasn't long before the Grayson County Program on Alcoholism was in full swing.

What facilities were made available to the people of Grayson County? One of the first programs carried out was the distribution to the schools of pamphlets, books and films on alcoholism and mental health. The State Program on Alcoholism was able to supply much of this material, with recommendations for additional sources, if needed. Through adequate education, youngsters began to learn the physiological and psychological effects of alcohol on the human body. This knowledge helped them make an intelligent decision about their use of beverage alcohol.

Meetings Set

Another aspect of the Program involved the setting up of monthly meetings for ministers in the county. Through group discussion, showing of films and the distribution of pamphlets, ministers learned that alcoholism is a sickness and were more helpful to those alcoholics who came to them for counseling. Church groups for adults and young people under the leadership of these ministers stressed alcohol education in their meetings.

Classes Held

Classes were held for teachers in the county public schools. They too learned more effective uses for the materials the Information Center had provided them and were soon conducting informal discussions on alcoholism in the classroom.

Thanks to Dr. Thomas, physicians in Grayson County entered into the program with great enthusiasm. With the Information Center providing them with literature, they were kept up-to-date on the latest drugs used for acute alcoholism and were notified of the various sources of treatment available to the alcoholic.

Displays on alcoholism and its symptoms were set up in the public library and books and pamphlets were given to the library for anyone who wanted them. It wasn't long before industry in Grayson, which had a large number of absentees attributed to problem drinking, recognized the need for alcoholism education and invited Mr. Anderson to speak to their management and employes.

Police Join In

Ed Harris, the Chief of Police, arranged to have films and discussions on the problems of the alcoholic made a part of the officer-training program.

The Alcoholism Program also worked with agencies in the county. The caseworkers in the county welfare department recognized the need for a happy, well-integrated home life in



the prevention of alcoholism and helped the husband or wife of an alcoholic who came for counseling understand his mate's despair and heartache at his illness.

Mr. Anderson and the Advisory Board were aware of a real need for educating more people of a professional level. With funds from the budget, a scholarship was set up to the Yale Summer School of Alcohol Studies. This scholarship was available to principals and supervisors in the school system and also to social workers, case workers, psychologists, physicians and ministers—any person whose work brought him into contact with the alcoholic problem. Scholarship aid was also provided for teachers in the county who wished to attend the North Carolina Summer Studies on Alcohol.

Jim S.

What about the alcoholic himself? How did the Alcoholism Program help him? Let's take the case of Jim S. Jim was an alcoholic and he needed help. He talked to Mr. Anderson at the Information Center about his condition, explaining that he had been drinking heavily for some years; he was now out of a job, family relationships were strained and he was broke and desperate. He realized that something had to be done.

Needed Help

From Jim's appearance and behaviour while he talked, Mr. Anderson realized that he was in need of immediate medical attention. He called the local hospital and arranged for Jim to be admitted that very day.

After the "dry-out" period, Jim was met by Mr. Anderson who took him to the Alcoholism Clinic in the next county. He told Jim the care he received at the hospital was only the beginning of his treatment. The Clinic would provide the psychiatric therapy necessary to his recovery.

At the Alcoholism Clinic, Jim first talked with the psychiatric social worker who took down his story and explained the inner-workings of the Clinic. She told him of the type of therapy he was to undergo during his initial visits and of the follow-up treatment available after he was ready to take his place in society. She explained that the fee for treatment was small, based on the family's income. While she talked, Jim felt the tenseness leave his body. He knew that here he would be helped.

Understanding Himself

After his interview with the psychiatric social worker, Jim was taken to the staff psychologist who gave him psychological testing. He was then introduced to the clinic psychiatrist. There Jim began the long-term process of understanding himself and his drinking.

Like most Alcoholism Clinics, this one was exceptionally well-staffed. The psychiatric social worker, psychologist and psychiatrist were all well-trained in treating alcoholics. They were able to help Jim as they had helped others before him.

The Beginning

With alcoholics able to receive adequate medical and psychiatric treatment and with the firm establishment of the Grayson Program on Alcoholism, the 15 people who met that first night feel they have the beginning of a realistic and scientific approach to alcoholism treatment, education and prevention in their community. It is the ultimate hope of the State Alcoholism Program that many counties in the state will follow Grayson in the establishment of a local alcoholism program. For only through local programs, with state guidance, can the fight against alcoholism be successful.

Program Pointers

(Continued from page 4)

expand our resources.

In the area of treatment, the demands upon us have not been so great, but this does not mean that the need is not there. The reasons for this lack of demand for treatment proportional to the demand for educiation is not conclusively known.

In the course of the life of our program we have been unable to engage in continuing research. Thus, our organization and services and our growth and development have been impaired because we do not have the advantage of having our ideas and plans tested and measured by scientific, objective research techniques. Only through a continuing program of research carried on by adequately trained personnel can we solve the many questions and problems related to alcoholism. The lack of research activity is not peculiar to the NCARP, but is common to many other state programs.

Without research to guide them, an organization may spend money and effort in areas where little or no good is done. This is an expensive waste. Even if an organization makes progress without research, there is no way to study their results to see why they succeeded in certain areas or why they didn't succeed in others. In our program we cannot even evaluate records kept on our patients. Through these records, we have available to us a great insight into the validity of treatment procedures, but because of lack of funds and personnel, this knowledge is lost to us. We need records of our program's experiences so they might be studied and examined, with an eye towards corrective measures and improvement.

In this issue of INVENTORY, we have attempted to outline some of our ambitions and thoughts, which according to our own experiences and the experiences of other states, appear to be sound, but we cannot improve and/or extend the services without additional funds.

At present, the Appropriations Committee of the General Assembly is studying our budget requests, along with the requests of all other state departments, agencies and institutions. The amount recommended by the Advisory Budget Commission has been disappointing and such that we can only continue in our present path, not being able to meet the increasing demands of our education programs, not being able to improve and correct our treatment programs, and not being able to instigate research programs.

An Appeal

Those of you who have expressed approval of our efforts, those of you who support the Program, who have found our material helpful, who recognize the need for advancement, can make a valuable contribution to the success of the NCARP. I am appealing to you to write your legislators, expressing your feelings about the Program. It would take you only a minute and the little time and effort you spend would be of untold help to us.

The future of alcoholism and the state alcoholism program rests not with the administration, staff or even in the governing board. It rests with the people of the State of North Carolina. It is you taxpayers who must decide what sort of service you want the Program to give. Do you want it to stand still or do you want it to advance and go forward? The decision lies with you. Won't you please write your legislators today?

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

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Raleigh

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MARCH-APRIL, 1957

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Will Group Therapy Help The Alcoholic's Wife?

The Alcoholic And The Opiate Addict

What Hospitals Can Do About Alcoholism

There's Something Wrong With My Daddy

What Churches Can Do About Alcoholism

If Your Wife Has A Drinking Problem

Steps To Oblivion

News From 'Round The World

Program Pointers

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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Educational Director

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Executive Director

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INVENTORY

VOLUME VI NUMBER 6

MARCH-APRIL, 1957

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.



News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

WASHINGTON: Memberships in Allied Youth, the scientific alcohol education program for teenagers, has increased to 17,768 or 20 percent over figures for 1955. Allied Youth was founded in 1931, and forms Posts as extra-curricular activities and educational clubs in high schools. There are 176 such Posts in the United States and Canada. Each Post holds two meetings a month: one an educational meeting to discuss alcohol information; and the other a social meeting featuring "Fun Without Drinking" for the younger set.

CHICAGO: The National Council on Alcoholism held its 30th nation-wide conference and annual meeting at the Hotel La Salle in Chicago on March 27, 28 and 29. Many outstanding professional people addressed the meeting. Included were Dr. William C. Menninger of the Menninger Foundation; Mrs. Doris Corwith, New York, supervisor of Public Service Programs for the National Broadcasting Company and past national president of the American Legion Auxiliary; and Leo Perlis, New York, director of the Committee on Community Services of the AFL-CIO. Many other leading medical doctors, psychiatrists, labor leaders, social workers, nurses and professional persons with authoritative backgrounds concerning prevention and treatment of alcoholism spoke at the various sessions of the meeting.

NORTH CONWAY, NEW HAMPSHIRE: The North Conway Foundation has chosen "The Church and Social Drinking" as its topic for the 1957 Alcoholism Institute to be held June 17-21 at Stonehurst in North Conway. Each June a group of 50 people representing all major religious bodies of America gather together to study alcoholism. The Institute is conducted on a graduate level and offers an opportunity for ministers and students to work under outstanding leadership.

NEW HAVEN: The Center of Alcohol Studies at Yale has received a grant of $80,291 for a new 5-year research project aimed at devising ways in which to measure the results of treatment of alcoholics in out-patient clinics. The grant was awarded by the National Institute of Mental Health of the U. S. Public Health Service and will cover the initial two years of the project. Ultimate aim of the project is to determine the effectiveness of treatment of alcoholics in the various states which spend an estimated $4,000,000 annually on these clinics. The Yale Center of Alcohol Studies will be in charge of the research program.

GREENSBORO: As a sidelight to the A. A. 1957 Convention to be held in Greensboro on May 24, 25 and 26, an employers workshop on "Alcoholism—The Relations Between A. A. and the Employer" will be held Friday, May 24, at 3 PM. All AA's are urged to contact any employers in your community who have an interest in alcoholism and tell them about the workshop. It's open to all employers and there is no registration fee. Employers who attend the workshop will receive a great amount of knowledge about alcoholism which will be beneficial to them and to AA.

AA's and non-AA's who would like to attend the 1957 Convention or the workshop can write for registration forms to M. Brice Rose, General Chairman, 1012 Carolina Street, Greensboro. Registration fee for those attending the Convention is $5.

RALEIGH: Really on the up-grade in attendance and effectiveness is the AA Group of the Central Prison in Raleigh. They report over 90% attendance at all meetings and a great deal of enthusiasm on the part of their members and outside friends and visitors. They are now publishing a newsletter called "The Balance Sheet" which writes in glowing terms of their AA group: ". . . it seems that only a real illness or the necessity of work can keep one of our members from a meeting."

NORTH CAROLINA: Ten county Mental Health Associations, special Mental Health Committees, and individuals in other counties will join the North Carolina Mental Health Association in celebrating 1957 Mental Health Week. This year's dates for observing Mental Health Week are April 28-May 5. The slogan for the Week is "The Mentally Ill Can Come Back—Help Them." This year the emphasis of the celebration will be the hopeful aspect of the mental health program in the nation. By urging the public to support all Mental Health organizations, it is hoped that thousands of mentally sick people may recover from their illness and be restored to their families and communities. Mental Health Week is directed nationally by the National Association for Mental Health in co-sponsorship with the National Institute of Mental Health of the United States Department of Health, Education and Welfare.

VERMONT: A telephone recording service to provide information for alcoholics, similar to services which give time and weather information, has been initiated in Burlington by the State Alcoholic Rehabilitation Commission, Joseph P. Verdery, executive director. The purpose is to make it easy for the alcoholic, his friends or relatives to get information anonymously and without obligation. To use this service, persons with a drinking problem call a publicized phone number. A different one-minute message each day in the week will give the caller basic, factual information on alcoholism. Director Verdery says that so far as he knows his Program is the first to experiment with this unique service.

OHIO: Two bills to establish a state alcoholism agency have been introduced in the State legislature. One bill would establish a bureau on alcoholism in the Department of Mental Hygiene and Correction, while the other would create a Division of Alcoholism in the state department of health.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

ONE of the objectives of the NCARP's educational program is to aid professional people who are concerned with alcoholism. We are eager to participate in and develop any ways in which we can contribute to the increased knowledge of alcoholism of any interested group or organization.

Last year we approached the three organizations chiefly concerned with professional nursing: the N. C. State Nurses Association, the N. C. League of Nursing and the N. C. State Board of Health. We wanted to know if they would be interested in a special institute on alcoholism to be designed for nurses. We know that many nurses come in contact with alcoholism problems in their work.

Interest Expressed

Each of these three organizations expressed interest and willingness to share in the sponsorship of such a program. Accordingly, a representative from each group met with us to construct plans for the 1956 Nurses' Institute on Alcoholism. Thus was formed two 2-day Alcoholism Institutes which met in Raleigh and Charlotte. The response of the nurses to the Institute was enthusiastic. One hundred and forty-five nurses registered for the two meetings.

This year we were approached by the nursing organizations themselves. They asked if we were planning an institute similar to the one held in 1956. Many of the nurses who attended last year had expressed a desire to conduct another Institute on Alcoholism, and many of the nurses unable to attend last year wanted to attend this year.

Planning Session

Again each of the three nursing organizations selected a member of their group and met in a planning session to arrange the program for the 1957 Nurses' Institute on Alcoholism. Elsewhere in INVENTORY, you'll find detailed information concerning the time, place and length of this Institute.

In March, the North Carolina Caseworkers Association held district meetings in ten different locations throughout the state. The Association selected as the topic for their meeting, "The Caseworkers Role with the Alcoholic". The NCARP was asked by a representative of their organization to assist them in their planning and to participate in the meetings. We were fortunate to be able to select such outstanding speakers as: Miss Anne Tillinghast, Chief Psychiatric Social Worker, Highland Hospital, Asheville: Mr. Jack Johnson, Chief Psychiatric Social Worker, Graylyn Hospital, Winston-Salem: Dr. Mintauts M. Vitols, Superintendent, State Hospital at Goldsboro: Mrs. Gladys Riddle, Psychiatric Social Worker, Charlotte Mental Hy-

(Continued on page 30)

VOL. VI, No. 6 INVENTORY MARCH-APRIL, 1957

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

WHAT CHURCHES CAN DO ABOUT ALCOHOLISM

A divinity student states why he believes the church's changing attitude is important in alcoholism education and prevention.

BY KENNETH ROUSE

MANY churches and church related groups have sponsored community projects in which alcoholism is recognized and approached as a disease. There is an increasing awareness of the fact that treatment and rehabilitation of the alcoholic is needed, rather than punishment or condemnation.

There is, of course, much diversity among churches in regard to their position on the use of alcohol. This is due in part to the lack of any definite teaching on the matter in the Bible. There is some ambiguity in the biblical views of the use of wine. It could be argued that Jesus used wine, and at no time condemned its use. On the other hand, Jesus did not teach in specifics. And many of his general and basic teachings cover excessive use of wine or other alcoholic beverages as sinful. Whatever were Jesus' particular views on the practice of moderate drinking, we know that he would be against anything in a society which was harmful to the people within. Here, I'd like to use Rev. Olin Binkley's words which express my convictions and, I believe, are in accordance with Jesus' will. Rev. Binkley says that churches which plead for total abstinence, base their criticism on three considerations:

1) Moderate drinking makes men careless of their social responsibilities and engenders hazards in our complex culture.
2) Popular consumption of alcoholic beverages is a factor in producing the disease of alcoholism.
3) Moderate drinking increases the

ABOUT THE AUTHOR

Kenneth Rouse is a student pastor, preparing for the ministry in the Disciples of Christ Church. He now serves two part-time rural charges—Southwest Christian and Stokes Christian Churches—in eastern North Carolina.

This article is a condensation of a term paper Mr. Rouse wrote while a student in a class on alcohol problems, conducted recently at Atlantic Christian College. The editors believed it worthy of publication and Mr. Rouse kindly granted his permission.

social pressure toward drink upon youth, and has a detrimental influence on spiritual development and religious achievement.

Because I believe this, I believe the goal of the church should be to encourage and promote total abstinence. However, I would emphasize again that the methods used in obtaining this goal are most important. It is essential that we remember not to let the "perfect" become the enemy of the "good."

Improving Attitudes

The first method of improvement is in our attitudes. Before we can even attempt to build sound working relations in the community, we must check our attitudes toward the problem. This is essential not only for providing worthwhile instruction to non-alcoholics, but for working with those who have the disease. We should strive to promote a community-wide atmosphere in which open-mindedness, objective thinking, and mutual helpfulness is evident. There is no room for the personality who consistently "criticizes and damns" in a program of alcohol education and rehabilitation. The development of constructive attitudes, as far as the church is concerned, has to begin with the minister. His approach in preaching and in personal contact is tremendously influential. The person, regardless of his position in the church or community, who thinks he has all of the answers and closes his mind to any new ideas or possibilities, promises to be detrimental to the cause of correction.

Much has been accomplished when laymen become receptive to new ideas, developments and teachings, and the findings of research. Ignorance is not so harmful as prejudice, if the ignorant are willing to learn.

Education Program

Secondly, the church needs to provide an organized program of education. This, of course, is not possible without trained efficient leaders in the department of education. A worthwhile investment by the church would be to sponsor and finance, if necessary, a program through which leaders could formally or otherwise receive the facts about alcohol, and gain a deeper understanding of the causes and effects of alcoholism . . . thus, better qualifying them to plan and administer a program of education within the church itself. This is possible through classes such as the one offered at Atlantic Christian College. There are many such offerings of which the public takes far too little advantage. Of course, wherever possible, it would be tremendously advantageous to have qualified personnel who are employed in the program of alcoholic rehabilitation to visit the church directly, and not only instruct or teach, but actually assist in helping to set up a program of education to be continued by the laity and the minister.

The church needs to cooperate with any and all groups and agencies in the community which are directly or indirectly associated with alcohol problems. Because of the all-important factor of "multiple-causation", this covers a wide area. It begins

with kindergarten and does not end short of the old folks' homes. Some of the principal areas in which intimate cooperation is necessary are the public schools, the county and/or city government, the city recreation department, the AA groups available, the clinics and hospitals, the state rehabilitation services, and most importantly the institution of the home or the family.

Wherever courses in alcohol education are offered as such, or where they are integrated into the other courses of study such as health, guidance, social studies and science, the church would do well to plan parallel courses of study in its program. Where there is no alcohol education in the public school, or where it is weak, the church can supplement with its own education program, and might be influential in encouraging the school to be more active in this area. The department of education in the church, being responsible to the Sunday School, the Youth groups, the Christian men's and Christian women's fellowships, and the various other auxiliary groups as well as to the combined program of education has the key position. If they are well-informed and dedicated to this area of responsibility, they can accomplish much. Through quiet, careful and persistent planning and working cooperatively, foundations can be laid which will make for many lasting results. This method is far superior to the waving of banners and the dramatic speeches of debate which have been used in the past. In some churches where the functional type of organization is well established, alcohol problems are listed under the duties of the world outreach or world relations committee. But in these cases, they would still be working in conjunction with the department of education.

Seeking to understand and then leading others to understand the purpose of groups such as AA, organized to help the alcoholic, is of unlimited value. We must not only be sympathetic with a sick person but understand the nature of his sickness if we are to help him. Here again, the minister is an important person. His interest in and cooperation with agencies giving constructive help to the alcoholic will be reflected by the congregation in their attitudes.

The church may assist in the betterment of community problems by encouraging and supporting better treatment of alcoholics in hospitals —in courts—and by the general public.

A vital part of alcoholism education is in the area of prevention. Adequate recreational facilities, well planned and supervised, are beneficial in many respects. They help to develop stable and mentally healthy individuals who are not susceptible to alcoholism. Since alcoholism is a top ranking public health problem, it is

A NECESSARY CONDITION

SOCIAL beings express their nature by creating and recreating an organization which guides and controls their behavior in myriad ways, which liberates and limits their activities, which sets up standards for them to follow and maintain, which in fact, in spite of all the imperfections and tyrannies it has exhibited in human history, is a necessary condition of every fulfillment of life.

R. M. McIver in "Community Organization and Planning"

easy to see the need for prevention.

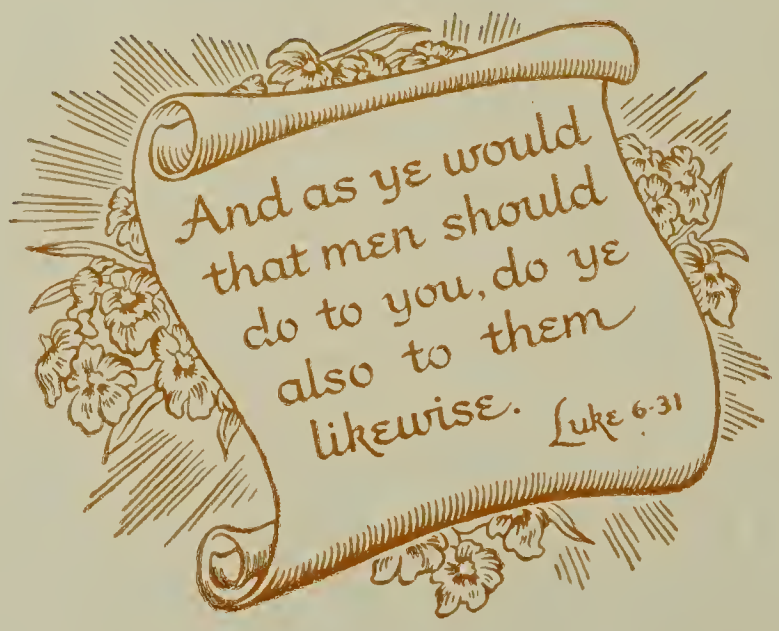
Pastoral counseling can be an effective means of both prevention and treatment. Certainly, confidence in the minister does a great deal for a person with problems. Sometimes, the sharing of these problems early enough can lead to correction, and save a potential alcoholic. If a person is already an alcoholic, he needs even more the true friendship of a man who lives close to God, and the assurance of understanding from others. The minister can do much through personal contact and counseling to fulfill both these needs.

Technique Would Vary

Little has been said about what actually ought to be taught in the program of alcohol education sponsored by the church. I have avoided this for one special reason. I do not feel qualified to specify a particular plan by which this could most effectively be done. It seems that the technique in each church would vary according to the situation. Hard and fast rules would only defeat the purpose. The needs of the particular community in question are of utmost importance.

Generally speaking, the true picture of the physiological aspects of alcohol, the treatment of alcoholism as an emotional illness, and a thorough investigation of the treatment, prevention and research possibilities, should be covered in any alcohol education program. Regardless of the channels chosen for this integration of knowledge and understanding, the same ultimate destination for it should be visualized from the first . . . that is, the family, the home. It is here that we find the crux to most of our many interrelated social and individual problems.

Finally, recognizing that alcoholism is a very complex problem, medically, morally, socially, and educationally, we need to recognize the challenge which faces all churches to combine their efforts. To increase our effectiveness, we need to locate our sense of direction, and through united spiritual planning, pursue our goals objectively.



What, if any, responsibility does the hospital owe the alcoholic? Are all alcoholic patients "drunken bums"? Read a frank discussion of

WHAT HOSPITALS CAN DO ABOUT ALCOHOLISM

BY IRVING GOTTSEGEN

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WHAT is there about the problem of the alcoholic patient that is so forbidding to the general hospital? Of all chronic diseases, alcoholism is the least acceptable and many general hospitals will not admit such patients.

The Public Health Service has called alcoholism our fourth largest health problem. There are four million alcoholics in our country at the present time. In view of this, it appears that the general hospital has fallen down in its duty to the public.

Many general hospitals which will not admit chronic alcoholics have the plausible excuse that they have neither the facilities nor the staff to handle "problem patients." Sickness, however, is a matter of degree, and who shall say where the line shall be drawn? In his introduction to the book published by the research council on problems of alcohol, E. M. Bluestone, M.D., said, "They (hospitals) and the medical profession are, indeed, so absorbed in the pressing problems of purely physical disease that they play into the hands of a sanctimonious group in our midst that would have such patients (alcoholics) 'stew in their own juice,' and who have no sympathy for scientific medical approach to this peculiarly baffling malady." With the improvement in the pharmacology in the treatment of alcoholism, the problem of the unruly patient can be minimized and the need for special disciplinary accommodations reduced. Hence, the argument often advanced that hospitals are not equipped to handle such "problem" patients is no longer convincing.

If an analysis of the peculiarities of this problem could be undertaken by each community and each hospital, and these analyses compared with the experiences of other communities, might not the public re-

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sponse in general, and the hospital response in particular, be different from what it is today? In Westchester County, (N. Y.) we approached the subject in this spirit.

In April, 1955, the Westchester County Council of Social Agencies, a coordinating body for all the social agencies in the county, published a study which revealed that there are 18,000 alcoholics in the county. The county has a total population of approximately 700,000. In order to determine what facilities were available for the care of alcoholics, 14 voluntary general hospitals, one proprietary general hospital, and one county hospital, were surveyed. It was reported that for the 12-month period of 1953, the 14 voluntary general hospitals admited a total of 82,-874 patients on an in-patient basis, and that during this period a total of 140 alcoholic patients were admitted to these hospitals—*but only because they were suffering from bodily injury complicating their alcoholism.* Only one voluntary general hospital reported that it would accept the chronic alcoholic for treatment. Ten reported that they would accept the chronic alcoholic for treatment only if some other ailment were present. Our county hospitals are in no way different from others throughout the United States. These figures do, in fact, mirror the unfortunate situation which prevails everywhere else in this country.

Shirking Responsibility

The alcoholic may be drunk and irresponsible, but when he is left to "sleep off" his condition elsewhere, the hospital is shirking its responsibility. It is allowing nature to take its course without the aid which is furnished to the more fortunate type of patient. Not until we classify alcoholism as a bona fide sickness of mankind, even though a bizarre and erratic one, shall we be approaching a solution. That such reasoning is realistic has been demonstrated by the experience of a number of general hospitals, both in the United States and Canada.

Alcoholics Are Ill

W. E. Hall, M.D., staff physician at St. Michael's Hospital, Toronto, Canada, in an article on alcoholics in the general hospital, says: "The vast majority of patients with acute alcoholism are not noisy, injured or encumbered by police and relatives at the hospital door. For the most part, they are fully responsible citizens, are very ill, and in great need of specific treatment." He points out that the experience of his hospital, where alcoholics are admitted to the general wards, demonstrates for the most part that these patients will accept whatever treatment is given to them, and that within 24 hours they are usually very cooperative and most often more appreciative than the average patient. A number of general hospitals in our own country have had similar experience, among them the Rochester (N. Y.) General Hospital and Knickerbocker Hospital, New York City.

As far as staff is concerned, the group practice principle which characterizes hospital service can be particularly useful with the alcoholic patient. For the rest, we can only ask for an extension of our attitude of kindness, sympathy, understanding, and a willingness to apply humanitarian principles to include the patient suffering from the disease called alcoholism. An orientation program in the subject of alcoholism is highly desirable here, as it is when other clinical conditions are under study. If staff limitations, especially in the nursing area, should hamper admission of the alcoholic to the general hospital, a plan similar to

the one used at Knickerbocker Hospital can be initiated. At this hospital, members of Alcoholics Anonymous act as volunteers in supplementing the work of the nursing staff. These are often dedicated people and they have proved to be extremely helpful. Other volunteers may well find this neglected field of activity very attractive.

Among the most important prerequisites for the acceptance of the alcoholic in the general hospital is a good educational program, beamed to the community in general and to the board of trustees in particular. The reluctance of hospitals to accept the alcoholic can be turned to acceptance through the need of the public if the process of education is carried out logically and effectively. It is important that the entire staff—administration, medical and nursing personnel, and all others—become aware that the alcoholic is a sick person and must be treated on a parity with any other person who is admitted to the hospital. The general hospital can profitably go a step further. In addition to admitting the alcoholic to the hospital, it should become the community-centered agency for the problems which this group presents.

Continued Therapy

Alcoholism, which very often must be classified as prolonged illness, can be treated in its acute phase inside general hospitals. After this phase subsides, plans should be made to continue therapy either on an in-patient or outpatient basis. If therapy is to continue in an outpatient clinic, it is best done in one that is affiliated with the hospital which was responsible for the treatment of the acute phase on an inpatient basis. In-patient treatment in the same hospital should be continuous and interchangeable to afford all patients greater security. Home care has its special opportunities in selected cases.

If it is not possible to continue treatment of the alcoholic patient on an out-patient basis after discharge from the hospital, arrangements should be made to transfer him to a long-term facility, preferably one which has an affiliation with the general hospital. This should provide him with continuity of care as well as security in the knowledge that he is not being returned to the environment which, in some measure, generated his current alcoholic episode, without an opportunity for further correction.

The long-term phase of hospitalization for the alcoholic should, in effect, be considered a problem in general rehabilitation. While continued therapy, both medical and psychiatric, is in progress, the patient should be subjected to a program designed to help him reconstruct his personality and make a better adjustment to his environment. Vocational counseling service should be available at this time if the alcoholic should seek new fields of endeavor. The vocational counselor, working with the clinical psychologist, and the tool of psychometric testing, can best evaluate the patient's vocational needs.

It is public need that has created the hospital. By deliberately sidestepping a public problem in medical care because it happens to present an unusual and difficult variety of social as well as medical problems, hospitals are missing opportunities in the prevention and cure of a disease and rehabilitation of patients. On the other hand, by helping to solve this vexing situation, hospitals will solve many other problems in the process. This is the acid test of hospital interest and usefulness.

IF YOUR WIFE HAS A

One of the best prescriptions for her recovery:

Love, Loyalty, Patience from you, her husband.



DRINKING PROBLEM

BY GEORGE ADAMS

"MY wife is an alcoholic. When I finally learned of her problem, I got some literature on alcoholism and read it carefully. I found lots of advice for *wives* of alcoholics, but little or nothing for a husband whose wife can't control her drinking. I began wondering if women alcoholics are such a rarity that nobody bothers mentioning them. I wondered, too, if the advice for wives applies to husbands of alcoholics as well. Or should women be handled differently? I love my wife and I want her to get well. But I don't know quite how to help her. Can you give me some advice?"

Husbands In Dilemma

More and more requests like this are finding their way into alcoholism information centers and clinics throughout the country. Husbands frequently are placed in a dilemma similar to this man's—disturbed about their alcoholic wives, but confused as to how they should help. Men tend to react more impulsively to the problem than do women. Many a husband of an alcoholic has walked out on his wife when her drinking first began to upset the routine of the home. Lack of understanding is probably the chief reason for their hasty action. If husbands really want to help their alcoholic wives, there are some things they should know about the woman alcoholic.

Alcoholism is not confined exclusively to males. About one out of six alcoholics is a woman, and some doctors believe their number is increasing. Researchers can only speculate about the possible causes of the increase. One of their hunches is that more cases of female alcoholism now report for treatment than in former years, when public stigma forced them to hide under a veil of secrecy and shame.

Another factor which may contribute to the increase is the changing role of women in American society. Women are moving into the competitive arena of business and public affairs—territories to which the male once held exclusive claim. As they do so, they learn to juggle the responsibilities of wife, mother and career woman. Some do marvelously skillful jobs of playing the three roles, but they pay a price in emotional tension and strain. If the mother-wife-career woman happens not to be a pretty well-adjusted person, the strain of her triple role may drive her to the bottle.

Housewife Susceptible

But the working wife is not the only type who may be susceptible to alcoholism. Her stay-at-home counterpart is not immune. Some women join the alcoholic ranks by way of the kitchen sink, the washing machine and the vacuum cleaner. And it is often possible for a housewife to conceal her problem drinking from her husband and friends for a much

longer time than the career woman, who is more in the public eye.

Jane R. furnishes a typical example of a housewife who reached the early stages of alcoholism before her husband had any inkling that something was wrong. Jane started sipping a glass or two of grocery store sherry for "a lift" in facing the monotony of household chores. Her husband, Bob, an aggressive salesman, left her alone all week while he traveled a high producing territory. Alone and lacking constructive outlets, Jane gradually increased her drinking, "graduated" from sherry to bourbon, and managed to keep a glow on during most of every day, Monday through Friday. When Bob came home on Friday night, he was ready to relax and go out on the town. For a long time, Jane went with him. Sometimes, their weekend relaxation included cocktail parties, where Jane consciously limited herself to one drink, so that neither Bob nor their friends were any the wiser about her home style drinking problem. As the months passed, Jane had increasing difficulty getting sobered up in time for Bob's homecoming. Finally, she began begging off from their weekend social engagements, pleading a "sick headache", "neuralgia," or a number of other physical ailments she invented to cover her drinking and hangovers.

Realization

Bob, oblivious to the real reason for his wife's peculiar behavior, begged her to see a doctor for relief of her physical complaints. Her repeated refusals baffled and irritated him. His first hint of Jane's drinking problem came when he unexpectedly arrived home sick in the middle of the week. Jane, surprised, mumbled something about "taking a little whiskey for the neuralgia," but her bedraggled appearance and heavy breath made Bob suspicious. Then, later, he discovered a half empty whiskey bottle hidden in the clothes hamper, another in the chest of drawers. The light dawned—his wife had a drinking problem and he had been too blind to see it! He couldn't believe it and neither could their friends, who recalled Jane's habit of nursing one lone cocktail at parties, always refusing a refill. But Jane was well into the early stages of alcoholism before she was discovered.

Drinking Pattern Differs

Jane's drinking pattern is fairly representative of many women alcoholics. They apparently drink differently from men. They seldom frequent bars, rarely become intoxicated in a crowd, and usually limit themselves to little or no alcohol at cocktail parties. Instead, like Jane, they frequently do their drinking quietly and within the privacy of the home.

There are reasons for a woman alcoholic's preference for solitary drinking. Although there has been some loosening of standards in recent years, there is still an unwritten law in most segments of society that women must not drink to intoxication. Marty Mann, in her book, *Primer on Alcoholism,* says that even "in the hardest drinking circles, the very men, and women, too, who drink the most often make the remark, 'If there is one thing I can't stand, it's to see a *woman* really *drunk.*'" Drunkenness in men may be slurred over and excused as a male prerogative, but in women it is still viewed by much of the public as a sign of depravity and degradation.

Women are acutely aware of this double standard. And because of it, the disgrace and humiliation and guilt of the woman alcoholic is many times greater than that of the male. The husband of an alcoholic must

recognize this fact. He should seize every opportunity to let his wife know that he understands that alcoholism is an illness, not a sign of depravity. This will ease her tremendous burden of guilt and may hasten her decision to admit the problem and seek help.

If the alcoholic woman is a mother as well as a wife, new problems are added. She heaps additional blame on her own head for being what she considers an "abnormal, neglectful" mother. This self-blame only fans the flames of her alcoholism. In some severe cases, where the mother is completely unable to attend to household duties, it may be helpful to send the children away for a while, perhaps to the home of a relative or close friend. But in many instances, the children can become partners with the husband in a plan to help Mother. It should be explained to them that she is suffering from a serious illness requiring each family member to exercise tact and patience to effect recovery. When they understand the cause of their mother's bizarre behaviour, children are better able to adjust to it without developing serious personality defects of their own. Even very young children are often capable of understanding, and can sometimes play a key role in the mother's recovery.

Boredom Is Factor

If there are no children, the problem may appear more easily licked. But this is not always true. The childless housewife who is an alcoholic is often at loose ends. Lacking the responsibilities of work or children, her motivation to seek help may be very weak. The husband has only limited opportunities, usually on weekends or an occasional evening, to help his wife develop the understanding of her problem. He must learn to make the most of the periods when he is at home and when his wife is sober and rational.

Through reading and talking with others close to the problem, the husband should learn all he can about alcoholism. Attending Al-Anon Family Group meetings or open meetings of Alcoholics Anonymous can be helpful. Even while his alcoholic wife is still drinking, the husband should investigate all nearby treatment facilities, learning their admission policies, fees, and methods of treatment. Out of all his information, he should evolve a tentative plan of recovery for his wife to consider when she finally reaches out to him for help. That plan might include initial medical treatment and hospitalization, in-patient psychiatric treatment, visits to an out-patient alcoholism clinic, joining Alcoholics Anonymous, counseling with an understanding minister, or any combination of these treatment resources.

No matter which road to recovery a woman alcoholic chooses, the outlook is hopeful. Clinic files, treatment center records, and the literature of Alcoholics Anonymous all contain case histories of alcoholic wives who have regained sobriety. Some doctors feel that as a rule, women are more difficult to treat and often need a longer period of treatment than do men. Women may have different types of personality problems related to their drinking. Their life adjustments after treatment may necessarily be of a different kind. But husbands should be reassured that there is hope and help for the alcoholic wife who sincerely seeks it. She has just as good a chance for recovery as a man does.

The best advice to husbands of alcoholics can be summed up in three words: Love—Loyalty—Patience. If you do love your wife—alcoholism and all—and decide to stay with her,

(Continued on page 30)

In confusion, an alcoholic's child cries



there's something wrong with my daddy

BY CLAIRE CHENEY

THERE'S something wrong with my daddy. I don't know what it is exactly, but I know something's wrong. When I ask him about it, he sometimes pats me on my head and tells me to run out and play with the other boys, but then other times he shouts and tells me to leave him alone. Those are the bad times . . . when his head hurts and he says he feels sick all over.

I wish I could tell my daddy how much I love him, but I guess I'm afraid of him, 'cause when he comes home at night, I want to run away and hide. I don't like to hear him when he's mad at Mother. I want to run and hide and get away from him, where I won't have to listen to him.

Sometimes he's nice and we go to the park and sit and watch the people walk by. He tells me funny stories that make me laugh and he laughs too. We have a good time. I wish it could be like that always.

Trip To The Zoo

One Saturday afternoon Daddy and I went to the zoo. They had just gotten a hippopotamus and Daddy said as a special treat we could go see him. Mother packed us a picnic lunch and she and Daddy smiled at each other and acted as if they liked each other a lot. We stayed at the zoo for about an hour and then Daddy said he had forgotten about an important appointment he had made. He told me to stay there and he would be back in a few minutes.

I waited and waited, but Daddy didn't come back. I was sure he wouldn't leave me there all by myself, so I sat down on a bench and made up stories to pass the time. It began to get dark soon. I felt sick all of the sudden. The zoo didn't seem as nice as it was before and the animals made funny noises. I wanted to go home. I yelled for Daddy, but he didn't answer. I knew then that he wasn't coming back for me. He had forgotten all about me. I slowly picked up the picnic basket that was still full of Mother's lunch and ran all the way home.

Mother cried when I told her daddy had left me, but then she hugged me and told me not to worry. I was her big boy now and I shouldn't let things bother me.

Daddy Comes Home

He came home that night long after I'd gone to bed. I heard him as he opened my bedroom door. He stumbled over the chair by the dresser and I knew then where he'd been. He hadn't had that 'pointment at all.

I pretended to be asleep when he kissed me goodnight. I didn't want him to know he'd made me cry. I was too old to act like a baby.

Why does my daddy have to be like this? Why doesn't he act like other daddies?

They tell me to play with the other boys, but they don't know that the other boys don't like me. They call me names and whisper about me, like they did the other day.

They were all playing ball in the front yard and when I asked if I could play too, they laughed and said, "We don't want to play with you. Your father gets drunk." You'd have thought that was the funniest thing in the world the way they laughed and pointed at me.

Nobody Understands

It makes me mad when people talk about my daddy like that and I feel like hitting them, but I know it won't do any good. They don't understand my daddy at all. They don't know how nice he can be sometimes.

I do have one friend, though. His name is Bobby, but we don't get to play together much because his mother and daddy don't like me

either. They tell Bobby he ought not to "sociate" with boys like me. I don't know why they say that because they used to have me over for supper and they seemed to like me all right then.

Always Fighting

Mother and Daddy and I used to have fun together, but we don't anymore. He's always fighting with Mother and talking mean to her. One of these days I think I'm going to run away. I would now except that I don't want to leave Mother. Lots of times I don't go home right from school, even though I'm suppose to. I go to a movie or just walk around until it's time for supper. I guess I ought to be punished, but Mother and Daddy are usually too busy arguing to notice whether I'm home.

Sorry

Sometimes I'm sorry I didn't come right home because then Daddy's feeling good and we have supper and he helps me with my homework. But I can't always tell when that's going to be. Anyway, I've found lots of interesting things to do after school. There's a crowd of boys on the other side of town who don't know me and they let me play ball with them whenever I want to. But it's a long walk over there and besides, I don't think they're as nice as the others.

I just *hate* my daddy sometimes. When he begins drinking that stuff, he seems to forget that Mother and I are even there. That's when it hurts the most and I go to my room, away from him. Sometimes I cry because he's acting like that, but I try not to because Mother says I've got to learn to be the man of the family. Other times I just lie back on my bed and think of how it's going to be someday . . . when Daddy's all right and we can be a real family again.

Someday

I *know* it's going to get better. One day we're going on picnics again, play games together and Daddy will like us all the time, not just once in a while like he does now. He'll come into my room and kiss me goodnight and I'll kiss him back and he won't stumble over the chair or smell funny.

I know it's going to be that way, because if Daddy knew how I feel all the time, I'm sure he'd change. I'm *sure* he would.

One day I'll have lots of friends and they won't whisper about me. I'll be happy then 'cause everybody will know there's nothing wrong with *my* daddy.

PROTECTING THE CHILDREN

HOW to protect children in the home of an alcoholic is a problem very close to the heart of every Al-Anon Family Group parent. In spite of all that can be done, children of active alcoholics usually become aware that there is something seriously wrong in their homes, making it very different from the homes of their playmates. Consequently many of these young folks have been more or less emotionally hurt . . . Many families have had remarkably good results by explaining to even young children that their father has been a sick man; that the disagreeable things he sometimes said and did were the results of his illness; that their real father always wanted to be kind and loving.

—from THE AL-ANON FAMILY GROUPS, A Guide for the Families of Problem Drinkers.

A report on an experiment in concurrent group therapy for alcoholics and their wives.

WILL GROUP THERAPY HELP THE ALCOHOLIC'S WIFE?

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EXPERIENCE in the treatment of alcoholism is steadily accumulating. At the same time, more attention is being given to the impact of this disorder on the family unit and to the involvement of the family members in a treatment program. J. K. Jackson of the University of Washington, Seattle, has depicted the onset of alcoholism as "precipitating a cumulative crisis for the family." Based on her observations of group discussions in an Alcoholic Anonymous Auxiliary, and on interviews with the wives of many alcoholics, Jackson delineated seven critical stages of the developing family crisis. She suggested that the picture which the wife presents may indicate not so much her basic personality as the stage in the family adjustment to the alcoholism of the husband. Thus, thinking of the family unit as the patient and as the proper focus of therapeutic effort may well offer a promising line of approach to the problem of treating alcoholism.

Experimental Therapy

At the Out-Patient Department of the Henry Phipps Psychiatric Clinic in Baltimore, L. H. Gliedman and his colleagues carried out an original

experiment in the group therapy of a small number of male alcoholics. The special feature of this study was that the wives of these patients were also involved in a discussion group, which met separately. At the time treatment was begun, the condition of the patients and of their wives was described according to a battery of evaluative measures. Later the effectiveness of the program was gauged by the changes that took place, in both the alcoholics and their wives, according to the same set of measures.

Unwilling Patients

The investigators did not easily find couples who were willing to cooperate in a study of this sort. Out of 45 couples approached, only 9 accepted the plan of treatment. All the patients tended to recognize alcoholism as their main problem, and all of them had some compelling reason for starting treatment, such as threatened loss of job, pressure from the wife, or severe financial setback. All might be said to have come to treatment unwillingly. All of the marriages were currently "battle-grounds" in various stages of crisis.

Evaluating Characteristics

Four measures were employed in evaluating the condition of the patients and their wives before and after the group treatment program. The first was a drinking checklist of 29 items describing characteristics of pathological drinking; each could be rated in terms of 4 degrees of severity. Both the patient and his wife rated the patient; thus an estimate could be made of the severity of the drinking problem as seen by the patient and by his wife. The second measure was a checklist of 33 psychological symptoms, such as anxiety, depression, irritability, obsession, on which each spouse separately rated the patient's condition.

The third measure, an adjective checklist designed especially for this study, also involved the self-judgment of the alcoholic and his wife's judgment of him. By means of the adjectives elected, such as mature, trusting, nagging, it was possible to judge the degree of satisfaction and dissatisfaction of each spouse with the marriage when the patient was sober and when he was intoxicated. Finally, following a structured psychiatric interview, the patients and their wives were rated on a "social ineffectiveness" scale made up of 15 categories of interpersonal behavior rated on a 5-point scale. The categories included, for example, overly dependent and overly independent, impulsive, over-cautious, superficially social, and sexually maladjusted.

Understanding Stressed

Group therapy sessions for the male patients were held twice a week for 16 weeks. For the wives, a weekly discussion group was held, with a woman leader who was not a physician. The meetings of the wives were not described as "treatment." Indeed, when the plan was originally presented to the couples, it was emphasized that the involvement of the wives was intended only to "broaden the base for recovery by insuring that both marital partners would better understand the nature of the patient's alcoholism and have a share in its amelioration."

Keeping Down Anxiety

The therapeutic orientation of the group sessions of the alcoholics was analytic in a limited sense. A special effort was made to keep anxiety from overwhelming the patients, and interpersonal reactions of patients to one another were rarely analyzed. In the wives' group, the sessions were more like the usual analytically oriented

group therapy. As time went on, the wives used the meetings more and more for therapy for their own problems as well as for participation in their husbands' recovery.

The results of the study, Gliedman and his colleagues state, must be considered as highly tentative, in view of the small number of cases (only seven couples completed the series of sessions) and the highly selected sample. Nevertheless, there are several decidedly interesting findings. Despite the fact that the patients entered treatment unwillingly, a condition which is ordinarily considered to offer small hope of success, many healthful changes took place in the patients' attitudes and behaviors. The investigators suggest that the adverse effects of reluctance may have been dissipated by involving the source of pressure—the wife—in the treatment program.

Morale Boosted

The greatest measurable changes that took place were in the area of "marital milieu"—the satisfaction of the patient and his wife with each other—and in personal morale. More than half the couples reported improved sexual adjustment and manifested "improved outlook with regard to marital status." Sobriety became more personally satisfying to the patients than it was prior to treatment; and the wives chose more of the complimentary adjectives to describe the husband when he was sober.

On the symptom checklist, significant decreases in irritability and in depressiveness were indicated by the patients and borne out by the wives' evaluation of their husbands. Also evident was a significant reduction in the patients' paranoid-schizoid symptoms.

Smaller though still important changes took place in the actual drinking behavior of the patients. Five of the seven alcoholics improved on the drinking checklist. Two were totally abstinent, two had reduced the frequency of their drinking behavior, however, there were only minor alterations on the social ineffectiveness scale.

Drinking Motivations

What does group treatment have to offer the alcoholic? In the view of Gliedman and his colleagues, an important motivation for excessive drinking may well be the need to cope with the damaged self-esteem, the low tolerance for feelings of depression, and the high sensitivity to experiences of failure, defeat and inadequacy that characterize the alcoholic. It is in regard to such feelings that the group makes its special contribution to treatment. The alcoholic is able to use one of his major personal resources, superficial sociability, in functioning in the group. Through this he can achieve satisfactions which enhance his esteem at the same time that he is learning other techniques of interpersonal relations.

There are other advantages to

THE MATURE PERSON

INDIVIDUALS who can accept their weaknesses and recognize their strengths, who can accept responsibility and face their problems, are usually emotionally mature. This maturity is a process of growth that doesn't have too much to do with age or physical development.

—From "Facts About Alcohol" by Raymond McCarthy

group therapy. An all-alcoholic group fosters mutual support and identification, ordinarily a difficult achievement for the alcoholic. Further, it permits the patient to take treatment at his own pace, to participate or to withdraw as he feels psychologically prepared to do while remaining physically present. At the same time, the alcoholic's tendency to live in the "here and now" can be more readily modified in a group.

Special Values

The involvement of the wives in the treatment program added several special values. The very willingness of the wife—who in many cases literally compelled her husband's attendance at the clinic—to participate in and accept some responsibility for his treatment, probably enhanced the patient's motivation and helped to sustain him through the course of therapy. With the wife herself involved, as in this program, the patient's accepting of treatment was less likely to be construed as an admission of guilt on his part, and less likely to be used as a weapon by the wife, than if only one of the pair were involved. The participation of the wives could also be considered as a sort of "tacit recognition of their own need to change." Finally, and perhaps most important, the procedure of concurrent groups had the effect of automatically emphasizing the marriage and the psychological factors related to it, without the use of special therapeutic means to achieve this end. The setting of the therapeutic task in terms of the family unit thus served as a frame of reference within which specific treatment could more readily occur.

Announcing —

1957 NURSES' INSTITUTES ON ALCOHOLISM

TIME AND PLACE:

April 24, Room 101, East Carolina College Gymnasium, Greenville, N. C.
April 26, Room 409, Buncombe County Court House, Asheville, N. C.

SPONSORED BY:

The NCARP, N. C. League for Nursing, N. C. State Nurses Assoc., and N. C. State Board of Health

INCLUDING SUCH OUTSTANDING SPEAKERS AS:

Robert H. Dovenmuehle, M.D., Psychiatrist at Duke University and Consulting Psychiatrist for the Keeley Institute, Greensboro, N. C.
Millicent Griffith, Assistant Chief of Nursing Education, Veterans Administration Hospital, Lyons, New Jersey
John A. Ewing, M.D., Instructor in Psychiatry, UNC School of Medicine, and Coordinator of Alcoholism Treatment and Research, North Carolina Memorial Hospital
Thomas T. Jones, M.D., Private Practitioner of Internal Medicine, Staff Member of Duke and Watts Hospitals
Member of Alcoholics Anonymous

No fees will be charged nurses who attend. However, they will be expected to bear their own traveling expenses, board and room. Nurses from other states are invited to attend one or both Institutes.



STEPS TO OBLIVION

The path to alcoholism has many backward steps, each stamped with a distinct warning.

BY CLAIRE CHENEY

SALLY S. is 33-years old, an alcoholic. She began drinking 10 years ago, sparingly at first . . . only at parties or when friends dropped by . . . then more and more frequently, until now she finds herself unable to control her obsession for alcohol . . . unable to control her life.

How did it all begin and how could Sally have recognized her first signs of uncontrolled drinking? If Sally had known and understood the symptoms of alcoholism, she might not be in the fix she is today.

Sally was born into a highly intelligent and doting family. As a child, she was given the best of everything until she began to take her untroubled way of life for granted. She graduated from college with honors, began a career, and soon afterwards met Ralph, a young lawyer who was to become her husband. Her family favored the match and her friends were envious of her newfound happiness. She was attractive, popular and Ralph loved her.

Soon they married, but Sally developed a longing to go back to her old job. She loved keeping their small

apartment but found many idle hours, especially in the afternoons when the housework was completed. She told Ralph she had decided to return to work, but to her amazement and anger, she was told she had a job . . . as his wife. Ralph said that the law practice was picking up and soon they could buy the small cottage they wanted. She'd have plenty to keep her busy then.

Sally was hurt but tried not to show it. She loved her husband, but she felt useless. She couldn't help Ralph with his work and her old unmarried friends no longer interested her. Certainly dishes and the dust mop were not good company. It was then that Sally found a new friend, one which was to wreck her life . . . the bottle.

It began slowly. Just a few drinks before dinner. Then a few after dinner, then a nightcap. Ralph didn't object, did he? Besides, he was seldom home. She never realized that preparing briefs and seeing new clients would require so much night work.

Parties were great fun, with a few drinks beforehand to perk her up for the evening ahead. Once amid the background of music and laughter, Sally found many opportunities to sneak into the kitchen for quick ones, hoping no one was the wiser.

WARNING SIGNAL
Sneaking Drinks

Sally loved the glow alcohol gave her and that wonderful feeling of being removed from everyone and everything. Alcohol could lift her spirits to new heights, with all cares and tensions fading away, leaving her the sole inhabitant of her own little world. Everything was going fine for Sally until one morning after an especially heavy drinking party, she was unable to remember what had taken place the night before.

WARNING SIGNAL
Blackouts

Fear of what was happening to her began to undermine Sally's confidence but as long as she had an ego-booster in the form of a drink, she felt secure. She kept two bottles hidden "just in case" and many times found excuses to look in the chest of drawers or in the attic for a "highball", as she called it.

WARNING SIGNAL
Solitary Drinking

EARLY SYMPTOM
Protecting Supply

As the months passed, Sally existed from one drink to the next, although she convinced herself that she could stop at any time. I have perfect control over the situation, she said. Besides, one more drink won't hurt anything. What did it matter anyway? She wasn't any good to anyone. Ralph had become married to his law practice, not to her.

EARLY SYMPTOM
The Alibi System

Sally's friends worried about her. She cut herself off from everyone and was even rude when they suggested she slow down on her drinking. She told them angrily she could do without their advice.

EARLY SYMPTOM
Anti-Social Behavior

Soon Sally and Ralph moved into

their new home and shortly afterwards Ralph, Jr. was born. Sally found it difficult to adjust to her new motherhood, and a few drinks during the day made it easier for her to keep going. She found it took more and more alcohol to get the desired effect, but this didn't worry her for long. If it took more, she'd drink more.

Ralph was concerned and asked her to give up alcohol, but Sally replied that she was drinking normally. What was *one* drink now and again, she asked him? But Sally knew she wasn't being fair with Ralph and experienced her first pang of remorse. I'll quit drinking, she resolved. No, I'd better not quit altogether. It might not be good for my system. I'll limit myself to 3 drinks a day. But the first drink called for another, another and then another, until Sally was off on a binge to oblivion . . . many times waking to find the baby crying, her once-spotless house disorderly and dinner not prepared. She was afraid but powerless to stop.



ALCOHOLIC SYMPTOMS
Deep Feelings of Remorse
Loss of Control

Sally got older, reasoning as the years passed that there was nothing she could do about her "weakness", so why should she fight it? Her aunt drank too much, so she must have inherited it. Nothing was wrong with liking a little liquor anyway.

Sally then began to feel the need for a drink as soon as she awoke . . . just to get the day started, she said to herself. By breakfast time, she sometimes had already consumed her one-time quota of 3 drinks a day.



ALCOHOLIC SYMPTOM
Desire for A Morning Drink

Sally and Ralph grew more and more away from one another, but Sally still had her good and best friend, the bottle. Her former friends no longer dropped by. Even her child avoided her when possible.

When Ralph suggested she go to the hospital for treatment, Sally replied angrily that she didn't need doctors. She had never had D.T.'s or embarrassed him in public, so why should he worry? What Sally didn't realize was that not everyone follows the same alcoholic pattern.

The few times Sally was sober, she realized what she was doing to her family but was unable to keep from drinking. She devised ingenious hiding places for her bottles, places where Ralph would never think of looking. Darn Ralph, Sally thought. If he had let me go back to work when I wanted to, I wouldn't be in this mess. More and more Sally felt sorry for herself and blamed Ralph and her child for her predicament.



ALCOHOLIC SYMPTOM
Unreasonable Resentments

Sally continued her alcoholic binges, drinking helplessly for days at a time, letting little Ralph and the house go uncared for. Nothing meant anything to her except alcohol. It was a beautiful monster that had taken over her life, leaving her weak and defeated.

Sally was now a full-fledged alcoholic. Routine household chores became a burden for her. Her hands trembled so she found it difficult even to light a cigarette. Sleepless nights left her exhausted. Even routine pressures of living filled her with anxiety and apprehension.



ALCOHOLIC SYMPTOM
Nameless Fears and Anxieties

The pattern of her life was set. One drink after another until Sally was drinking nearly a fifth each day. Her need for alcohol had so consumed her that she could hardly spare the time away from alcohol to do necessary family shopping. She lost weight from lack of food and her appearance became sloppy and dirty. When Ralph criticized her or pleaded with her to quit drinking, she drank only more to show him she didn't need his approval or anyone else's. Sally had built her own private world, a world which she alternately loved and hated.

Had Sally recognized the warning signals before they grew into the symptoms of alcoholism, she might have sought help and thus avoided the agonizing turmoil that had been her life for 10 years. Sally was emotionally disturbed, as are all alcoholics. From her life as the center of her parent's existence, she was suddenly thrown into a situation in which her wants and needs were not always catered to. For relief, she turned to alcohol.

Not every alcoholic has experienced the same symptoms as Sally or in the same order. Many alcoholics have symptoms that Sally didn't have, such as *prolonged benders* and *bizarre drinking behavior*. A few drinkers become alcoholics in several months; others take as much as 20 years. But all alcoholics have a common denominator . . . an inability to control their drinking.

Heed the symptoms of alcoholism. If you find that alcohol is becoming too important to your mental and physical well-being, *slow-down*. If you can't be moderate in your drinking habits, get help at a Mental Hygiene Clinic or see a private physician who has a thorough knowledge of alcoholism, before you find yourself well on the way to alcohol addiction.

NOBODY ever becomes a problem drinker overnight; as a rule it takes years for alcoholism to develop. So there's generally plenty of time to spot the symptoms and arrest the disease before it gets very far along. Even after a person has crossed the borderline, something can be done about it.

—From ALCOHOLISM, edited by George N. Thompson, M.D.

ALCOHOLICS are not all cut from the same pattern. They come from all walks of life, with varied family and educational backgrounds, and they have different personalities. They become alcoholics for various reasons. So alcoholics can't all be lumped together as one type of person. All they have in common is an inability to control their drinking.

—From "Facts About Alcohol" by Raymond McCarthy

IF AN individual who had been drinking in a controlled manner arrives at a stage where he can no longer take it or leave it alone but finds the need for alcohol irresistible, he joins the rather numerous group of addicts.

—From ALCOHOLISM, edited by George N. Thompson, M.D.



THE ALCOHOLIC AND THE OPIATE ADDICT

Copyright 1957 by Journal of Studies on Alcohol, Inc., New Haven, Conn.

THE moderate use of alcoholic beverages by most people is associated with pleasure and relaxation. Drinking by the addicted individual, however, produces chiefly painful effects. It follows that such a person's motivation for drinking must be largely outside of his awareness and, hence, not accessible to ordinary control mechanisms.

Opiate drugs too can be used in a harmful way. And though their effects are dramatically different from those of alcohol, the opiate addict seems to share many of the alcoholic's psychological problems. The two types of addiction have been compared recently by D. L. Gerard, a researcher at New York University.

The alky can't live with it, while the opiate addict can't live without it; but their emotional needs are similar.

Perhaps the most crucial difference

between the two, Gerard observes, is the experience of acute intoxication. As a person gets more and more drunk, there is a gradual decline in his motor coordination, intellectual functioning and social behavior. Nearing stupor, the intoxicated person's behavior may appear entirely unreasonable, perhaps psychotic. The stage of feeling high or happy is relatively brief in the total episode of alcohol intoxication.

Peace

With opiates, however, the sequence of events is as follows: After the dose is taken, there is a brief period of nausea which may be followed by "effortless and emotionally non-distressing vomiting"—especially for the novice. Next come intensely pleasant feelings, both physical and psychic. Bodily warmth, pins and needles, itching sensations of a somewhat erotic nature, and a feeling of impact in the stomach which is akin to a sexual orgasm are part of the somatic experience. Meanwhile, in the psychic realm, the individual becomes relaxed, free from tension and anxiety, pleasantly detached from the outside world as though all his demands had been fulfilled and everything taken care of.

Unlike alcohol intoxication, there is no deterioration of faculties or performance. "The opiate user's intoxication is of such a nature that he can be aroused at any time to participate in normal activities in a manner which would not distinguish him, except to the skilled observer, from a sober individual . . . He may function more slowly than ordinarily, but his efficiency need not otherwise be impaired."

The opiate addict generally neither desires nor achieves oblivion. As opposed to alcohol intoxication, his "high" period stays high for a number of hours without any painful consequence. Following the phase of maximum pleasure, there is a gradual return to normalcy. "The user returns to his normal activities but continues to maintain, although to a lessened degree, the comfort, detachment and loss of tension which he had experienced most intensely in the first hour or two after taking the individually proper amount of drug." There is no loss of control during opiate intoxication. The individual has no desire to take more than the intended dosage, hence he achieves just exactly the result which is consciously sought. There are none of the discordant and humiliating episodes which characterize a drunken orgy.

Deterioration

Repeated or chronic intoxication also produces important differences in effect, depending on the drug. The confirmed alcoholic becomes progressively more sick, more unhappy, and more deteriorated in every sphere of his life. Intermittently he will probably require periods of hospitalization. The chronic user of opiates, however, is comfortable and functions well as long as he receives large enough doses of the drug to



AND there's the drunk carrying a bottle in his inside breast pocket who fell face-down on the sidewalk. Slowly regaining his senses he stirred—then, fearfully he felt the warm wetness spreading over his chest. His blood-covered hand dropped limply into the gutter and he muttered with relief: "Thank God!! It's only BLOOD!"

—From "FUN 'N' FANCY"

stave off withdrawal symptoms. True, most opiate addicts develop tolerance, both physical and psychological, so that ever larger doses are needed to achieve the same results. Their bodies become dependent on the drug to maintain relatively normal function, and if they are deprived of it, their withdrawal symptoms will be excruciatingly painful.

Unlike Effects

Here, then, is the critical difference between alcoholism and opiate addiction: The alcoholic becomes increasingly tortured while he continues to drink. The opiate addict has comparatively nothing to fear unless he is deprived of his drug. This difference probably accounts for the fact that alcoholics occasionally become opiate addicts whereas the latter rarely become alcoholics, in spite of the fact that psychologically the two types of addict seem to be not too unlike.

Alike Goals

Primarily their goals are the same. They share a need to regress to an infantile level of satiation and contentment, a need to blot out painful inner tension. Equally significant is that they can perform this magic without any outside help—they are able to give to themselves what they want just by putting something into themselves. Gerard found that they are usually very isolated individuals who "deeply question the likelihood, at least for themselves, of mutually rewarding adult relationships." The experience of self-administered intoxication perhaps replaces, perhaps symbolizes autoerotic gratification. Both types of addicts are likely to be persons whose personality development was arrested at an infantile level.

The dependence-independence conflict is another area in which both addicts show marked problems. "Consciously, the alcoholic and the opiate addict experience difficulty in caring for themselves as independent, competent, mature adults, while unconsciously they often desire and fear a passive relationship with a stronger person who will care for them." This would account, for example, for their "flights into custody" where they can be almost completely helpless in the institutional routine and yet can rationalize that this dependent state was forced upon them against their will.

The desire for self-punishment is another shared trait. The price paid for their transitory pleasure includes not only delirium tremens and the acutely painful withdrawal symptoms but guilt, depression, insult and loss of social status. Yet they continue to return to intoxication "against their better judgment." In harming themselves in this way they are also incidentally punishing hated persons out of their past. Gerard observed that when an addict talks piously of having to give up alcohol, or opiates, because "I am hurting my mother so much,' he is getting ready for a relapse.

Since both alcoholism and opiate addiction seem to be different paths to the same goal—deep, regressive, infantile satisfactions—the treatment of both illnesses would logically be similar. Insight into the unconscious motivation is an essential first step. Strengthening of whatever mature

THE RUBAIYAT OF OHOW DRYYAM

When thyself at last shall come to trip
Down that dim dock where Charon loads his ship,
I'll meet thee on the other wharf if thou
Wilt promise to have something on thy hip

—From "ALCOHOL, SCIENCE AND SOCIETY"

elements are latent in the personality would follow.

In Gerard's clinical experience, one of the major difficulties in the treatment of both alcoholics and opiate addicts is "their extreme sensitivity to the dependency aspects of therapeutic relationships, so that they may run away from treatment in order to impede awareness of dependent wishes directed toward the therapist."

The ostensibly painful consequences of both addictions can be used for therapeutic ammunition. Theoretically the alcoholic should be more susceptible to treatment because through alcohol he never successfully achieves the effects that he is seeking.

If Your Wife Has A Drinking Problem

(Continued from page 15)

give of your love in generous amounts and have no regrets over your decision. Don't wear your wife's illness as a badge of your own martyrdom. She will sense it, though you may never express your regret in words, and it will only add to her feelings of guilt.

Let your wife know repeatedly and in no uncertain terms that you understand her condition to be the symptom of illness, not willful contrariness. Point out that hers is not a hopeless situation, that sources of help are not far away. And let her understand that you are prepared to stand by her, always eager to help, until she is willing to take constructive action to arrest her illness. Finally, adjust yourself to the possibility of waiting for what may seem an interminable period to see any results of your efforts. It may take time, but your wife's recovery will more than repay you for the "lost" hours and weeks and months.

Program Pointers

(Continued from page 4)

giene Clinic: Miss Elba Dyer, Chief Psychiatric Social Worker, Cumberland County Guidance Clinic, Fayetteville.

Other speakers included Miss Beatrice Coe, Psychiatric Social Worker, Forsyth County Child Guidance Clinic, Winston-Salem; Mr. Arthur Fabrick, Chief Psychiatric Social Worker, Buncombe County Mental Hygiene Clinic, Asheville: Mrs. Virginia O'Connell, Social Worker, Forsyth County Program on Alcoholism, Winston-Salem: Miss Roberta Lytle, Psychiatric Social Work Consultant, N. C. Alcoholic Rehabilitation Program, and Rev. Roy Barham, Chaplain, State Hospital at Butner.

The nurses organizations and the Caseworkers Association are typical of the many groups we should like to work with. We are looking forward to having such a relationship with all professional groups who normally are brought into contact with problems of alcoholism. We have had many planned teaching seminars with local ministerial associations, though unfortunately, up to now we have had little opportuity to work with physicians.

We are currently considering what we hope will be an appealing learning experience for physicians who wish to know more about alcoholism. Our present considerations include the opportunity for a clinical-teaching workshop in a hospital setting where physicians will have the opportunity to work with the alcoholic along with physicians and other professionals, experienced in treating alcoholism.

ATTEND SUMMER STUDIES ON

FACTS ABOUT ALCOHOL

FOR TEACHERS AND PROSPECTIVE TEACHERS

Offering Three Quarter Hours College Credit

- **NORTH CAROLINA COLLEGE**
 Durham, N. C.
 June 10-21, 1957
- **A. & T. COLLEGE**
 Greensboro, N. C.
 June 24-July 8, 1957
- **EAST CAROLINA COLLEGE**
 Greenville, N. C.
 June 17-27, 1957
- **APPALACHIAN STATE TEACHERS COLLEGE**
 Boone, N. C.
 July 22-Aug. 2, 1957

The State law requires that instruction about alcohol be given in the public schools. The North Carolina Alcoholic Rehabilitation Program, recognized as a leader in the field of alcoholism treatment and education, co-sponsors this course with East Carolina College, North Carolina College, A & T College, and Appalachian State Teachers College. For details and tuition costs, write the Registrar of the nearest college.

LECTURERS

FRED ELLIS, M.D., Associate Professor of Pharmacology, University of North Carolina.

PETER W. EVERETT, Ph.D., Chairman, Graduate Physical Education, Appalachian State Teachers College.

W. H. GAMBLE, Dean of Men, A. & T. College.

N. M. JORGENSON, Ph.D., Director, Dept. of Health and Physical Education, East Carolina College.

NORBERT L. KELLY, Ph.D., Education Director, NCARP.

B. T. McMILLON, M.S.P.H., Chairman, Health Education Dept., North Carolina College.

S. K. PROCTOR, Executive Director, NCARP.

SOME OF THE SUBJECTS COVERED

The Nature and Extent of Alcohol Problems

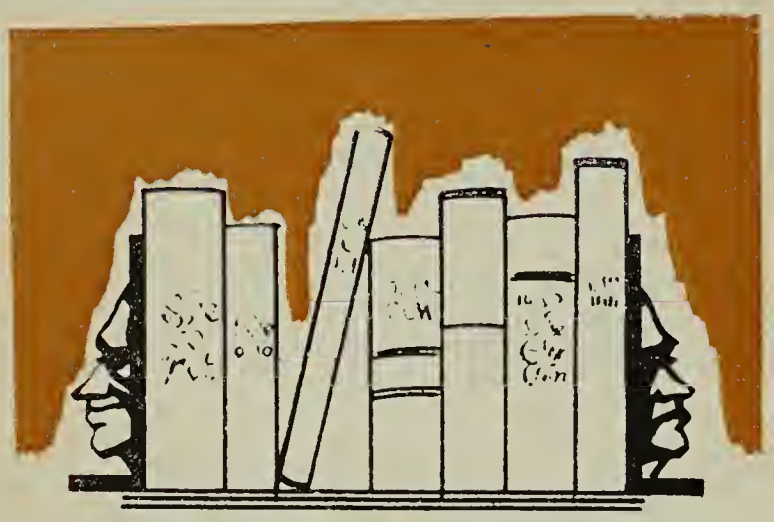
An Educational Philosophy for Instruction About Alcohol

The Dynamics of Personality Development

Organization of Materials, Procedures, and Techniques for Instruction About Alcohol

Some Aspects in the Causation and Treatment of Alcoholism

Educational Procedures and Techniques in the North Carolina Schools



Books of Interest

HOW TO LIVE 365 DAYS A YEAR

By John A. Schindler, M.D.

New York: Prentice-Hall, Inc.

"WERE your last 365 days a thrilling series of gloriously alive moments?", asks the author in the very first chapter of this volume. Most people would have to answer, no. If you are among them, this book may interest you.

The author, director of a large midwestern medical clinic, believes that most people, instead of living happily, merely "muddle through" life beset by worry, fear, apprehension and irritations. Unfortunately, muddled living produces emotional stress which, if prolonged, often results in physical illness. Dr. Schindler says that over 50 per cent of all illness seen by doctors is emotionally induced illness, or psychosomatic illness, whichever term you prefer. The author is not primarily concerned with alcoholism per se, but in view of its similarity to many of the psychosomatic illnesses we may logically assume its inclusion as one of the paths which emotional stress may take.

Part I of this interesting book is devoted to a detailed yet understandable explanation of how emotional stress causes physical distress and even serious illness. We learn that the so-called "unpleasant" emotions—like fear, anger, and self-pity—when experienced over long periods may produce bodily changes resulting in disease symptoms.

At the same time, the author stresses that the so-called "pleasant" emotions—like equanimity, resignation, courage, determination, and cheerfulness—are just as powerful a force toward *good health* as the stressful emotions are toward bad health. Upon this premise, Dr. Schindler bases what he believes to be a practical solution to the problem of emotional stress due to muddled living.

Part II of the book outlines a blueprint for replacing stress-producing emotions with health-giving ones. Schindler calls it the "learning-maturity" method. In a nutshell, he believes that emotional stress is the result of faulty learning, and that healthy emotions can be achieved by learning and practicing the qualities comprising maturity. The author has employed this method with numbers of his patients who suffered from emotionally induced illness, and claims to have experienced excellent results.

The author points up a number of life areas where maturity is especially important for the individual to possess. Entire chapters are devoted to developing mature attitudes toward sexual expression, family life, employment, old age and others.

Don't expect to read this book as a quick cure for anything that may be bothering you. You'll be disappointed. It contains much valuable know-how for more mature, happier living, no glib panaceas.

—George Adams

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-Patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

STATE LIBRARY OF NORTH CAROLINA
3 3091 00822 3075

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.